TOWARDS A MORE POSITIVE FUTURE FOR AUSTRALIAN PUBLIC HOSPITALS

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EXECUTIVE SUMMARY

1. **Australian tax-payers contribute $18 billion per annum to our Public Hospital system**[1]. This equates to approximately $900 for every person in Australia in 2004 or $1,700 for every person without private health insurance or $350,000 for every public hospital bed p.a[2] or $4,535.94 per public hospital separation[3]. Nevertheless the failure of our public hospital system to cope with the demands placed upon it is a major issue in all states and territories of Australia,

2. The Royal Hobart Hospital is indicative of the **decline of a once great public institution.** The hospital board has been replaced by a state government bureaucracy whose prime purpose is to ration hospital care. Consequently, operating theatre time is regularly rationed and cancelled, elective surgery is regularly cancelled at the last minute aggravating patients and staff, the absolute number of hospital beds has declined over the last 10 years, (albeit official bed numbers and unofficial bed numbers rarely agree), staff overtime is limited or prohibited. In summary, **productive capacity is continually disrupted lowering morale and increasing the frustration of those who attempt to work in such a system.**

3. **Why, when we are spending $18 billion per annum on our public hospital system does it continually fall short of community expectations?** The answer is a combination of factors.

   Firstly, **we have created a government charitable hospital service that claims to offer unlimited health care on demand as a right to every citizen regardless of circumstances.** Increases in funding do not relieve the pressure on the system. **As it improves, it attracts greater demand.**

   As former NSW Premier, Bob Carr publicly stated, *"as fast as we hurled money at the hospitals, there was a further abandonment of private health cover and a further rise in demands on the public system"*[4].

   Secondly, funding our public hospital system does not come through the front door with each patient (voluntary funding). **The majority of revenue comes from compulsory taxes through the back door in the form of annual budgets designed to meet political objectives.**

   Dr Max Gammon observed of the British National Health System ***"In that 8 year period [1965-1973] hospital staffs in total increased in number by 28%, administrative and clerical help by 51% but output as measured by the average number of hospital beds occupied daily actually went down by 11%)"*** Dr Gammon hastened to point out this was not because of any lack of patients to occupy beds. **At all times, there was a waiting list for hospital beds of around 600,000 people.**[5]

   US economist, Milton Friedman concluded that Gammon's Law was also at work in the US health care system. He found that ***"from 1946-1996 the number of beds per thousand population fell by more than 60%, the fraction of beds occupied by more than 20%. In sharp contrast input skyrocketed. Hospital personnel per occupied bed multiplied 9-fold and costs per patient day adjusted for inflation, an astounding 40-fold…. Gammon's Law, not medical miracles was clearly at work"*** [6]

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[1] AHIW 2002-03 published September 2004 @ $16.234 billion growing on average @ $818 million p.a.
[2] Based on total beds of 51,459 as per Source Data for The State of our Public Hospitals June 2004
[3] Based on 396,8303 public hospital separations as per 2000-01 at footnote 2
[4] Budget 1999-2000 The Government's Private Health Insurance Plan. www.health.gov.au
[5] Free to Choose – M & R Friedman, pp 114, quoting M Gammon, Health & Security December 1976 pp 18, 19
[6] How to cure Health Care – Milton Friedman. pp 12 The Public Interest, Winter 2001

Our public hospital system is caught in a double whammy. Any improvements in productivity will be swamped by increasing demand while government funding generates Gammon's Law.

Hence, in order to dampen demand **we have deliberately set out to manage the public hospital system near to crisis.** We ration care and treatment because there is no price mechanism to regulate supply and demand. At worst, we set our public hospitals up to fail; at best we severely limit their ability to succeed (if by success we mean having a hospital bed and an operating theatre for those whose clinical condition requires it). **Into this process we expect our doctors and nurses to deliver 1st class medical treatment, nursing care and world's best training of the next generation of doctors and nurses.**

Unless and until we confront painful realities we will continue to suffer, as the Soviet Union once did, all of the blights of the command and control public hospital (economy) system.

Should we summon the political courage to fund our public hospital system by directly **funding its patients** so that public hospitals can provide care and not ration it, we will start to see our once great public hospitals **rise again. Australian public hospitals will then enjoy a more positive future.**

Stephen Milgate
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OBSERVATIONS

Public Hospital Costs

1. In 2001-02 the **average cost for an admitted patient** to an Australian public hospital was **$3017**[7] albeit the cost of a procedure may vary considerably (it is claimed[8] that a low birth weight baby can cost up to $112,000 per separation with same day chemotherapy estimated to cost $700 per separation).

2. According to Australia Institute of Health & Welfare (AIHW) the costs of treating a patient in a public hospital was broken up as follows: Nursing 29%, Medical 20%, **other staff 15%, other 15%,** diagnostic 8%, supplies 8%; Drugs 5%[9].

3. Approximately **$18 billion** in taxpayer's money is being spent on public hospitals in 2004. This equates to approximately **$900 for every man, woman and child in Australia**[10] or **$1,700 for every Australian without private health insurance**[11] or $350,000 for every public hospital bed per annum.[12] or $4,535.94 per public hospital separation.[13]

4. A senior surgeon at a major teaching hospital in Brisbane asserts that only 25% of the hospital's budget is provided for surgical procedures.

5. The authors of this report have had considerable difficulty obtaining specific information about public hospital costs and note Categories (in point 27) such as 15% other and 15% other staff – it is not known what percentage of medical costs is attributed to Visiting Medical Officers but given sessional rates in most states the percentage is not considered to be significant.

> **Conclusion 1**
> $18 billion for a population of 20 million people is a significant investment in a public hospital system considering that around 42% of the Australian population also carries private health fund membership.

Cost Shifting

6. This activity has now become a major pre-occupation and skill of public hospital CEOs across Australia. There are two main strategies. **Privatised out-patient clinics** where all patients are billed to the Commonwealth Medical Medicare (administered by the Health Insurance Commission, HIC) program and the **"Twister"** where patients are introduced into the hospital as self-insured (hence covering some of their costs and being subsidised for others), i.e. partly public or an "intermediate" patient. The Central Sydney Health Service (CSHS) is reported to operate a scheme which charges $270 per patient bed day being met by the patient. The doctors' fee is paid by the patient and the patient claims back a rebate from medical Medicare. All other costs are met by the public hospital from Hospital Medicare (funded by State governments from

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[7] Source: Australian Institute of Health & Welfare (2003) – Australian Hospital Statistics 2001-02
[8] A public hospital administrator who does not wish to be identified.
[9] Source: Australian Institute of Health & Welfare (2003) – Australian Hospital Statistics 2001-02
[10] AHIW 2002-03 published September 2004 @ $16.234 billion growing on average @ $818 million p.a.
[11] Assuming 53%without private health insurance of a population of 20 million
[12] Based on Public hospital beds total 51,459, Source Data for The State of Our Public Hospitals, June 2004 Report, Australian Government Department of Health and Ageing., pp 19
[13] Ibid, pp 19, 3968303 public separations p.a. in 2000-01

consolidated revenue and the Federal Government under The Australian Hospital Care Agreement, AHCA).

Conclusion 2

Cost shifting has become an artform in most Australian public hospitals. Public outpatients in some hospitals have been "privatised" to allow for transfer of costs to the Commonwealth. Other schemes including the Twister have created an intermediate class of public patient partly contributing to some costs on a user pays basis.

The Public Hospital Blame Game

7. The problems of Australia's public hospitals are well known. The public is bombarded with headlines of long waiting lists, acute bed shortages, accident and emergency rooms overcrowding, industrial unrest and occasionally **failure to deliver what the community determine as adequate care.**

8. The traditional response to the anxiety created by these stories has been for **State Governments to blame the Federal Government** accusing it of contributory negligence through under-funding.

9. The Federal Government's response is to point out the **millions of dollars in funding allocated to the states under the Australian Health Care Agreements** (AHCA) and other grants as well as the revenue supplied by the GST which exclusively flows to all states from the Commonwealth.[14] Under the 1998-2003 AHCA the Commonwealth claims to have provided $31.7 billion to states and territories representing "***a nominal increase of 43.5% over the previous agreements.***"[15]

10. In **2004-05 GST revenue provision to states and territories** is **$34.46 billion** of which $1.4 billion is earmarked for Tasmania representing an annual average increase over the previous 5 years of 9.3% (Australian average increase 9.1%)[16]

11. **Calling public inquiries is a popular strategy** for dampening public anxiety over public hospital shortcomings. Some of the most recent inquiries include, "5 Year Health Action Plan (ACT), Better Health 5 Year Plan (NSW), Strategy 21 Directions 2005 (NT), Queensland Health Smart State, A Vision for the Future (QLD), Generational Review 2003-2023 (SA), Final Report reducing Demand on Public Hospitals (VIC), A Healthy Future for West Australians (WA).[17]

Conclusion 3

The public hospital blame game is a political strategy designed to relieve public anxiety over perceived shortcomings in the public hospital system. Both Commonwealth and state politicians are well practiced in the art of blame shifting. Fundamental truths about the inability of public hospitals to ever meet expectations of unlimited health care on demand for all Australians at no direct cost are rarely acknowledged. Spin (official lies) and political posturing is used as a substitute for confronting reality. A cynical public understands the game being played and looks on with increasing skepticism.

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[14] Source: Who pays for Public Hospitals? Australian Government Department of Health and Ageing - 22/9/04
[15] Ibid
[16] Budget Paper No. 3, 2004-05, Commonwealth-State Financial relations
[17] Richardson Report page 15

GST providing increase in Revenue

12. In the period 2000-01 to 2004-05 all states GST revenue grew **national averages (9.3% vs. 9.1%).**

13. All states and territories **have received windfall GST revenues** since the commencement of GST payments to the states and territories (only NSW required a top-up in 2003-04 to get the guaranteed minimum funding). In 2004-05 all states will receive above minimum payments[18].

The Recovery of Private Health Insurance

14. In January 1999 the **Federal Government introduced a 30% rebate** for all health fund members.

15. **The number of patients admitted to private hospitals in the 5 year period to 2002-03 has grown at a faster rate than admissions to public hospitals.** In 1998-99 there were 4,019,000 admissions to Australian public hospitals and 1,908,000 admissions to private hospitals. By 2002-03 public admissions were 4,237,000 and private admissions were 2,581,000 or a 5.4% increase in public admissions over the period compared to 35.27% increase in private admissions.[19]

Conclusion 4

The revival of private health insurance has provided relief for the public hospital system. Private hospital admission rates have grown at a faster rate than public hospital admission rates.

The History of Public Hospitals

16. Public hospitals have their origins in Christian charitable organisations. These institutions grew from the community's compassion for the sick, usually exemplified through strong leadership by individuals who felt convicted to help others.[20]

    The **state acquisition of public hospitals has its genesis in the French Revolution** when the State took over Church institutions in France. Many public hospitals were built by secular organisations dedicated to humanitarian works. However, many of these had strong religious affiliations. Hence, **public hospitals were, in the majority of instances, created through community effort and not at the instigation of governments** who have traditionally concerned themselves with matters of public health including upgrading water and sewerage facilities and health prevention programs.

17. A significant number of what is now Australia public hospitals, commenced as community hospitals founded by citizens through subscription and benevolence.

18. Prior to the introduction of hospital Medicare **admission into an Australia public hospital was means tested** in some Australian states. Many hospital doctors were appointed on the basis of an honorary contract allowing them the right to treat private patients at the public hospital in return for treating public patients without fee. Some **honorary contracts** still remain in the

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[18] Appendix B

[19] Source Data for The State of Our Public Hospitals, June 2004 Report, Australian Government, Department of Health and Ageing, pp 12

[20] Hospitals and Hospitality-The Health Report, ABC Radio National, 16 February 1998

Australian public hospital system but they have been **largely replaced by sessional payment** contracts for Visiting Medical Officers of fee-for-service contracts.

19. Prior to advent of university courses for nurses, **most large Australia public hospitals trained nurses on an apprenticeship basis** with the hospital being the major centre of teaching and training.

Conclusion 5

The concept of public hospitals has moved from charitable organisations to government owned and controlled hospitals. Centralisation of control and funding has followed these changes to what is now a command and control model.

ANALYSIS

20. The **problems experienced by public hospitals** exist in all states and territories in varying degrees. These problems can be summarised as **ongoing inability to meet the service delivery demand despite relative increases in taxpayer funding.**

21. Since 42% of Australians have private health insurance it stands to reason that a substantial number of the population are not solely reliant on the public hospital system for all aspects of their healthcare. There are, however, constraints to the investment in private health infrastructure that will limit the ability of private hospitals to take greater pressure off the public hospital system. **The repeal or reform of the Lawrence Contract Legislation by the Federal government would see a substantial increase in the desire of private hospital investors to expand in all States.**

22. In a productive industry (not always the case) increases in investment will be more than matched by increases in productivity. Hence, increased investment leads to lower unit costs and greater opportunity for profit which in turn drives increasing investment. Almost all industries face costly challenges including increasing technology and compliance costs. Properly managed, the dominant players in a competitive industry will be those that can meet the challenges and still provide a product or service that the market will be attracted to, i.e. the price/value relationship will be sufficient to win the customer. There will be failures and those failures are generally devoured by those who succeed, i.e. the laws of supply and demand operate in a contestable market - the winners survive, the losers don't. **Our public hospital system does not operate in a contestable market.**

23. There is no question that **innovations in hospital care have increased productivity** (decreased bed stays) e.g. many procedures in public hospitals are now being done as day-only procedures. However, this innovation of itself has not seen a significant improvement in reduced waiting lists for cases requiring considerable operating theatre time and hospital admission. Observations elsewhere (Refer Observation 25) leads to the conclusion that minor procedures often have a shorter waiting list than elective major procedures in our public hospitals. Given the recent growth in emergency departments we may be seeing the advent of 3 hospitals in 1, namely -the emergency department hospital; the day surgery; and the elective surgery and medical patient overnight stay hospital.

24. The ability of government programs to absorb increased funding and lower productivity was identified by British physician, Dr Max Gammon in his 1976 study of the National Health Service (NHS) in Britain. US Economist, Milton Friedman found the same trends in the US health care system. The summary of their work is essentially that where government funding (money that does not come with the patient or customer) is introduced into a system it has the propensity to get diverted to a number of areas including growing the bureaucracy and not reach its targeted destination in the same quantum (medical treatment and hospital care). This is sometimes described as **feeding a canary through a horse**). There is every reason to believe that Gammons law is operating in the Australian public hospital system) where beds are often closed to open desks. Hence, as funds increase, costs increase, and productivity in terms of hospital beds available for seriously ill patients declines.

25. Several factors have contributed to making it difficult, if not virtually impossible for public hospitals to meet public expectations.

26. By funding public hospitals on an allocated budget basis (soft money) and expecting them to spend that money on public patients who are seeking services on a demand basis. We have created a system where **public hospitals do not earn income from what they do** (i.e. they do

not earn hard contestable money). We have, as Friedman described, created a system whereby other people (health departments) spend other people's money (taxpayer's funds) on other people (public patients). In public policy terms this is a funding mechanism with the weakest linkage between those making the spending decisions and those using the system, i.e. instead of hospital income arriving through the front door with the patient and matching his/her treatment needs and costs; it arrives through the back door with the hospital budget and matches political demands and government spending constraints.

27. In reality this means that no-one on the hospital site has ownership or direct interest of cost or value of a service. **As public patients we have little or no interest in the cost of the service** or its efficiency cost-wise. We want to be looked after and with justification as we are taxpayers who believe we have already paid for the service. **Some of us will be too sick to worry about anything**. Those working in the public hospital can only follow the budgetary system imposed by hospital and health department managers whose prime function is to ration services as a substitute for the non-existent price mechanism which directs resources according to the laws of supply and demand.

28. **We have established a system where everyone is a "consumer" but no-one is directly paying at the point where the service is delivered or demanded. As public patients we turn up (or are taken) to a specialised hotel (hospital) on a government expense account. This is not the fault of the public patient or those that work in public hospitals. It is the system we have created for ourselves.**

29. **We have put our public hospitals in the worst possible situation** expecting them to provide a service on a commercial basis whilst funding them on a political basis. We have set our public hospitals up for failure.

30. Our public hospitals are **no longer community charities** where those wanting help understand and respect the limitations placed upon organisations who rely on public goodwill to survive. They are **not government departments** where benefits can be tightly regulated by strict legislated eligibility requirements. They are **not commercial businesses** where customers pay for a service and the customer/supplier relationship determines what is provided at what price and to whom. **THEY DO, HOWEVER, HAVE THE WORST ELEMENTS OF ALL THREE MODELS**

31. To add to this liability, our public hospital system has been compelled to adopt the **buzzwords and jargon of the commercial corporation** (or what some think is the language of the commercial corporation). Public hospitals have been compelled to have **mission and vision statements**, refer to stakeholders, adopt critical path analysis, involve staff in regular strategy planning meetings. Hospital administrators and medical superintendents are now CEOs and managers. **Patients are consumers** (as if being admitted to a hospital is similar to a shopping expedition). Doctors are service providers. Nursing sisters are simply nurse, or Mary, or Joan, as per your local shop assistant. One of the consequences of this "culture change" (which has gone on largely unchallenged) has been to encourage us, as public patients to behave like customers transacting with a commercial organisation as if we are spending our own money on a service being provided for profit. Expectations of service on demand have been fueled by this "modern approach" to hospital management. Hospital care that was once considered a privilege is now a right.
"We are also witnessing the increasing expectations of patients to participate in decision making associated with their treatment and to be fully appraised of circumstances as they unfold. The patients and the community will become more aware of the need to prioritise services to match the available resources. There is a growing understanding that hospitals are health service providers and, as a service industry, have customers who have rights and

expectations against which our service will be assessed. " Mr Ted Rayment, CEO Royal Hobart Hospital, 9 April 2003

32. The fallacy of pretending that public hospitals are commercial institutions ignores the fact that to succeed hospitals, and in particular public hospitals, must reverse the way a commercial organisation should operate. To succeed, a commercial organisation trading in a competitive market, will cease financing products and services that are losing money or have no potential to make it (dogs) and re-assign these resources to products which are making money or have the potential to make money (cash cows and rising stars). i.e. the weak are killed off; the strong are made stronger (putting on muscle). By this method, all resources are made more productive and the commercial organisation grows. Of particular interest to commercial managers is the product or service which, when properly financed, actually lowers productivity (the bomb, the dud, or the lemon). Competent management will treat this as a malignant tumour threatening the survival of the organisation. It will be radically, surgically removed as soon as possible. Fat may be tolerated for a short time as long as it has the potential to become muscle, if not it too, will be eradicated.

33. In a public hospital the opposite is the case. **The objectives are compassionate and humanitarian and not commercial.** These are special institutions once highly regarded because of their compassion for the sickest members of our community. In the well-run public hospital the sickest patients often attract the most resources sometimes with little prospect of recovery. Everyone's life is considered valuable and everything that can be done is done. Unlike the for profit business, in a public hospital money and manpower are diverted to those who are in greatest clinical need, i.e. it's often about savings lives where possible and relieving suffering. There is also an acknowledgement that the public hospital is primarily for those patients who will recover to the extent that they can leave the hospital. The terminally ill are treated in a specialised hospital or hospice where palliative care and specialised nursing and medical treatment maximise comfort and aim to help patients die peacefully and as painlessly as possible. In this case, maximum resources are devoted to those who will never recover because we believe that every day of every life is valuable. Where separate palliative care is not available the public hospital may also be called on to fulfill this function.

34. **The public hospital's unique role means that in order to operate efficiently, (i.e. be able to distort resources from the strong to the weak and still look after everyone,)** co-operation is essential. This can only be achieved if all participants are working as independent professionals in a highly motivated atmosphere with compassion and clinical results being the shared goal of all staff from cleaners to the most senior nurse and clinician. In a well run public hospital the administration role (turning chaos into order and ensuring supply) is vital. The management role (controlling and directing) is redundant. There is simply no capacity to pay for management supervision and since professionals, by definition must be capable of working independently and as part of a team, paid supervision is limited to the more junior staff. Accountability is paramount, senior medical and nursing staff in particular have very important roles in ensuring the appropriate balance between medical treatment and patient care. This does not imply that a well run public hospital is a laissez-faire environment. To the contrary. To make it work, routine and order must be maintained as agreed and committed to by all staff. Finally, there are minimal overheads with all resources directed to the treatment of patients. **Working in a functioning public hospital is more than a job.** It is a unique role that **requires professional skill and compassion and a willingness to work hard in the interest of patients by everyone from the accountant to the cleaner.** Finally, there is a difference between working hard and hard work. Sound administration will provide opportunities for the former and eradicate the latter.

35. A further obstacle to public hospital progress is the policy dilemma of making things worse by trying to make them better, (or at least making things more costly by trying to make them less costly) e.g. spending money on trains makes them more attractive for car travellers. As roads empty due to car users transferring to train travel for their journey to work, the former car users look out of their crowded train windows and see fewer cars and drivers on the roads. Drivers speed down the near empty roads enjoying the benefits of their car air-conditioning and CD players, i.e. driving to work has improved in value. It is not long before our new train travellers go back to their cars and gradually the status quo prior to the investment in train travel returns. Sadly, the investment in improving train travel is never repaid by dramatically increased patronage. This dilemma was described by NSW Premier, Bob Carr in 1993, ***"as fast as we hurled money at the hospitals, there was a further abandonment of private health cover and a further rise in demands on the public system"***[21]. This dilemma means that public hospitals have to define their priorities in care. They cannot simply pretend to offer service on demand to everyone who demands it. Nor can they turn away those who need urgent medical treatment. Furthermore the possibility of introducing some charges into public hospital usage must be seriously considered (there is sufficient evidence that this is now occurring in some Australian public hospitals on an informal basis) if this dilemma is to be avoided or minimised. It must be recognised in any well run charity, those who can afford to pay something are usually requested to do so.

36. The tendency to reorganisation as a panacea to avoiding difficult decisions has been historically observed. ***"We trained hard, but it seemed that every time we were beginning to form up into teams, we would be reorganised. I was to learn later in life that we tend to meet any new situation by reorganising and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation."***[22] Despite the lessons of history, the Government keep trying to reorganise itself out of a public hospital dilemma.

37. The effect of the most State Government Public Hospital Reorganisation has been to centralise the system in a more command and control model in response to the failure of local boards to meet government directives on budget. As such Australian public hospitals have lost any semblance of being community owned and controlled public hospitals. **In Dr Max Gammon's terminology Australian Public Hospitals have been fully bureaucratised and according to Gammon's Law are now exhibiting the same behaviour as all other bureaucratic systems i.e. using more cash and struggling to meet demand.**

38. In summary, **Australian public hospitals have acquired largely by government directive, the worst aspects of a number of different organisations** i.e. they are a mish-mash and some would say a mis-match. Although they are **best described as government charities they are largely incapable of engendering the good-will of a well-run highly regarded community charity essentially because they are perceived as open-ended charities that are capable of meeting all demands placed upon them.** When they fail, they are pilloried.

    Into this government charity model has been injected all of the demands of a consumer culture. A person receives privileges from a charity. But in the new consumer world of public hospitals a consumer demands rights. **All of the trappings (costs) of a commercial organisation have been burdened onto the public hospital.** Increasing management layers (to control ever-growing cost), consultant fees, IT departments, marketing, public relations, rigid industrial relations and work to regulations. Everything except the paying customer.

    Furthermore, these government charitable hospitals are not directly administered by the donor tax-payer (the contributors to the charity). Instead they are administered by often

[21] Budget 1999-2000 The Government's Private Health Insurance Plan. www.health.gov.au
[22] Gaius Petronius in 66AD

faceless public servants who we have appointed to make decisions on the operation of the hospital from a position of anonymity. Instead of being rewarded for meeting community needs in a compassionate way, **we reward these public servants for being able to ration patient demand and creatively withdraw services to meet pre-determined budgets. The rationing decisions will rarely include cuts to bureaucratic overheads.** Beds, not desks, are closed in order to keep on budget. The result is a frustrated workforce with low morale generating increasing demands for higher remuneration or voting with their feet and leaving the system.

Although our government charity is administered by public servants who, in other areas, achieve high standards of public administration, they are unable to deliver the certainty and stability that normally accompanies a well organised and professional public service. **Some public servants may even be called on or required to take the blame for public failures of the system in order to save their political masters.** The salary is usually reflective of this risk. Others simply leave and join the lucrative public hospital consulting circuit (industry) kept fed by an increasing number of state government reorganisations and inquiries.

Finally, faced with political responsibility for this government-owned quasi commercial charity **few health ministers will be willing to display the political will** (some would say political death-wish) to **confront let alone untangle the public hospital system we have created.**

Not that there is much likelihood of any potential public hospital legislative reformer attracting the necessary political support to make important reforms possible. **It is simply easier to perpetuate the existing system and apply political band aids, official lies (spin) and blame shifting.** The role of State Minister for Health is seen by politicians of all persuasions as undoable. It is a poison challis that must be survived. Public hospital reform is an area that not even the iron lady, Margaret Thatcher, ventured to tread.

SUMMARY

We have created an unworkable monster. We have created a government charity which we have promoted as being capable of unlimited funding of Health Care on demand. Medicare, and in particular Hospital Medicare, promotes no restriction on what can be delivered. Hence, a patient in intensive care in Sydney's St George's Hospital in November 2004 is the subject of court action by relatives who seek legal rights to maintain life support contrary to clinical advice. In order to deliver the impossible dream we expect hospital administrators, doctors and nurses to ration hospital care in a way that contrives to continue the conspiracy. The reality is that, in order to control demand and expectations whilst still advocating universal free treatment for all, our public hospitals must be run at just above crisis level. Bed numbers are kept down, operating theatre time must be rationed, elective surgery delayed, and vital areas of the hospital undermanned.

The art of managing the Public Hospital system is now the art of deception. This system will continue as long as the public has the capacity and willingness to be deceived. When we are ready to confront reality we can consider real reforms to enable our Public Hospital system to function and fulfill its purpose.

The recommendations in this report are for when that time arrives.

RECOMMENDATIONS

1. **Australian public hospitals be paid for what they do as they do it -**

   Under this recommendation, all funding allocated for public hospital patients from state and federal sources could be held by a **captured public hospital insurer**. Eligible public patients could then be funded by the insurer through a voucher for services in the public hospital system at agreed realistic commercial rates according to eligible criteria. This public hospital insurance model could be developed to provide a number of flexible options according to patient needs. The bottom line is to have the public hospital, like other hospitals be able to earns revenue directly from treating patients. In this way the hospital can arrange its affairs according to what it does and not according to Government budget dictates.

   This recommendation has the capacity if properly implemented to concentrate hospital resources on patient activity and eliminate or reduce overheads which have no direct bearing on patient care or treatment. It means that costs must be justified in terms of revenue. It also means that reforms such as "fee for service" can be built in to the operating budget.

   It will not work if the financier or captured insurer is given authority to dictate what happens in the hospital. The 2 functions must be kept separate and negotiation on a viable commercial basis entered into for charges. Arrangements between health insurers and private hospitals could serve as a starting point for negotiations between the public hospital and the captured health insurer.

   The captured insurer could also become a vital point of de-identified data collection for public hospital boards and other interested parties.

   What would not work would be a empowering of the captured insurer to call the shots on day to day treatment. This would be nothing more than the failed US managed care model. Both captured insurer and public hospital must be separate functions brought together by commercially realistic contractual arrangements.

2. **That Australian public hospitals be returned to community ownership through the establishment of individual hospital boards with the authority to operate all aspects of the public hospital they govern.**

   This recommendation is a natural flow-on from recommendation 1. Given that the public hospitals are now earning revenue for what they do on a commercially realistic basis, it stands to reason that a savvy hospital board should be put in place to administer all aspects of the hospital. The board must be best and brightest and most capable of citizens who understand the unique function of a large public hospital. Senior medical and nursing staff must be strongly represented on such a board.

   These boards must have the ability to make all decisions which concern the operating of the hospital without political interference. This may include implementing charges for some ancillary services.

   The authority of the board to negotiate employment conditions at the hospital will be an important reform. It will create essential flexibility which will assist with productivity.

   The Board could encourage the restoration of voluntary help for the hospital where appropriate with proper public recognition for all those who make a contribution. Some doctors in

particular, senior consultants may be willing to act as honorary doctors to the hospital.

Since the Hospital Board will have the authority to run the hospital it stands to reason that some of that authority can be delegated to senior hospital administrators and medical and nursing staff.

The tendency to stack hospital boards with political aspirants or token consumer representatives or mates must be avoided and opposed. There is no more important public service than taking responsibility for a major public hospital on which so many people will rely for their well-being.

3. **That public expectations of what the public hospital can deliver be redefined.**

Meeting the reasonable expectations of reasonable people – public doesn't mean "on demand". Together with the appointment of local hospital boards and changes to funding arrangements, the redefinition of what a public hospital can and cannot provide will be an important step in assisting the public to plan their health care needs.

The hospital is not able to provide instantaneous service for all healthcare demands and where possible, patients should utilize alternative facilities including ensuring that they have a regular general practitioner for non-emergency medical complaints. In addition patients with chronic and life threatening illness must be given speedy access to facilities with a minimum of administration.

All patients using public hospitals should be informed that there is a need to assist the community by making their pathology available for research and cooperating in the teaching and training of new hospital staff, junior doctors and nurses. This may mean that those doctors and nurses attending to patients may be under the supervision of senior personnel as trainees of the hospital.

The public should also be encouraged to sign up as volunteer helpers of the hospital to provide extra services at no cost to public patients.

The public should also made aware of any charges for ancillary services and/or financial contributions to care that may be requested on admission for certain types of patients in certain circumstances. The role of the public hospital insurer would be to publicise the type of funding that is provided to public patients and in what circumstances.

4. **That public hospital boards reintroduce a hospital based apprenticeship training system for nurses and that centres of nursing training be established at each teaching hospital to facilitate on-the-job training of nurses.**

The apprenticeship system of training of nurses and specialist doctors has been unduly maligned and degraded. Hospitals which were once vital centres of teaching have run down this important function which acted as a catalyst for continuous improvement and learning for hospital staff. Both doctors and nurses have valuable experience and observations that should be imparted to all staff sometimes on a case observation basis.

In order to overcome the shortage of qualified nurses (somewhat contributed to by an insistence on university education as a basic requirement for registered nursing, and also by under-rewarding good quality hands-on nursing which has seen many qualified nurses leave the workforce) each hospital should be directed to institute an apprenticeship system whereby young school leavers can be apprenticed to the hospital as junior nurses and rise to registered

nurse via an in-hospital training system. This junior workforce should be utilized to undertake as much of the routine work as is suitable to their age and experience as well as move to higher responsibilities based on an internal assessment of their suitability for higher level work.

University courses or advanced tertiary training for nurses can be made available for those apprentices who show dedication and aptitude for the work. Given the practical skills already learned the tertiary courses could be condensed and intensive for higher level work.

FINCIAL & FUNDING INFORMATION

Commonwealth, State & Non government public hospital expenditure.

Source: **Health Expenditure Australia (various years), AIHW, last issue for 2002-03 (published in September 2004) has State/Territory data to 2001-02 only. Five years of data included here to give a bit of context.**

Panel A: Commonwealth Government expenditure on public non-psychiatric hospitals ($m)

State/T	1997-98	1998-99	1999-00	2000-01	2001-02
NSW	1,911	2,305	2,411	2,628	2,768
VIC	1,354	1,662	1,728	1,867	1,992
QLD	1,016	1,147	1,181	1,302	1,388
SA	619	573	673	669	696
WA	577	640	667	688	779
TAS	171	151	152	163	174
ACT	97	86	94	103	103
NT	91	86	72	76	81
Total	**5,836**	**6,650**	**6,978**	**7,496**	**7,981**

Panel B: State/Territory Government expenditure on public non-psychiatric hospitals ($m)

State/T	1997-98	1998-99	1999-00	2000-01	2001-02
NSW	2,503	2,682	2,354	2,309	2,352
VIC	1,446	1,308	1,498	1,802	1,536
QLD	932	934	1,017	1,027	1,075
SA	362	453	478	500	288
WA	603	611	687	695	1,047
TAS	74	123	162	149	201
ACT	138	168	145	144	193
NT	57	73	106	105	178
Total	**6,115**	**6,352**	**6,447**	**6,731**	**6,870**

Panel C: Total expenditure on public non-psychiatric hospitals ($m)

State/T	1997-98	1998-99	1999-00	2000-01	2001-02
NSW	4,804	5,273	5,243	5,453	5,696
VIC	3,113	3,308	3,553	4,096	4,009
QLD	2,037	2,151	2,280	2,421	2,569
SA	1,023	1,073	1,188	1,208	1,031
WA	1,273	1,324	1,439	1,465	1,915
TAS	277	294	338	341	418
ACT	258	278	267	270	323
NT	165	178	196	201	273
Total	**12,950**	**13,879**	**14,504**	**15,455**	**16,234**

Panel D: Government expenditure on public non-psychiatric hospitals ($m)

State/T	1997-98	1998-99	1999-00	2000-01	2001-02
NSW	4,414	4,987	4,765	4,937	5,120
VIC	2,800	2,970	3,226	3,669	3,528

QLD	1,948	2,081	2,198	2,329	2,463
SA	981	1,026	1,151	1,169	984
WA	1,180	1,251	1,354	1,383	1,826
TAS	245	274	314	312	375
ACT	235	254	239	247	296
NT	148	159	178	181	259
Total	**11,951**	**13,002**	**13,425**	**14,227**	**14,851**

Panel E: Non-government expenditure on public non-psychiatric hospitals ($m)

State/T	1997-98	1998-99	1999-00	2000-01	2001-02
NSW	390	286	478	516	576
VIC	313	338	327	427	481
QLD	89	70	82	92	106
SA	42	47	37	39	47
WA	93	73	85	82	89
TAS	32	20	24	29	43
ACT	23	24	28	23	27
NT	17	19	18	20	14
Total	**999**	**877**	**1,079**	**1,228**	**1,383**

Panel F: State/Territory government share of government spending (%)

State/T	1997-98	1998-99	1999-00	2000-01	2001-02
NSW	56.7%	53.8%	49.4%	46.8%	45.9%
VIC	51.6%	44.0%	46.4%	49.1%	43.5%
QLD	47.8%	44.9%	46.3%	44.1%	43.6%
SA	36.9%	44.2%	41.5%	42.8%	29.3%
WA	51.1%	48.8%	50.7%	50.3%	57.3%
TAS	30.2%	44.9%	51.6%	47.8%	53.6%
ACT	58.7%	66.1%	60.7%	58.3%	65.2%
NT	38.5%	45.9%	59.6%	58.0%	68.7%
Total	**51.2%**	**48.9%**	**48.0%**	**47.3%**	**46.3%**

Index of government spend	100.0	108.8	112.3	119.0	124.3
Index of non-government spend	100.0	87.8	108.0	122.9	138.4

Figure 1: Health Expenditure Australia

GST Revenue

Source: **Budget Paper No. 3, 2004-05, Commonwealth-State Financial relations**

Panel A: GST revenue provision to S&Ts (cash, $m)

State/T	2000-01	2001-02	2002-03	2003-04	2004-05	Av increase
NSW	7,258	8,132	9,080	9,691	9,648	7.4%
VIC	5,099	5,593	6,365	6,974	7,151	8.8%
QLD	4,658	5,019	5,888	6,575	7,169	11.4%
SA	2,279	2,477	2,859	3,154	3,213	9.0%
WA	2,355	2,518	2,910	3,160	3,529	10.6%
TAS	988	1,060	1,247	1,399	1,408	9.3%
ACT	473	544	616	661	664	8.9%
NT	1,226	1,290	1,515	1,684	1,679	8.2%
Total	**24,335**	**26,632**	**30,479**	**33,297**	**34,460**	**9.1%**

Panel B: Projected GST revenues ($m)

State/T	2003-04	2004-05	2005-06	2006-07	2007-08	Av increase
NSW	9,691	9,648	10,317	10,922	11,447	4.3%
VIC	6,974	7,151	7,691	8,269	8,840	6.1%
QLD	6,575	7,169	7,630	8,068	8,541	6.8%
SA	3,154	3,213	3,372	3,556	3,734	4.3%
WA	3,160	3,529	3,660	3,783	3,989	6.0%
TAS	1,399	1,408	1,487	1,560	1,623	3.8%
ACT	661	664	697	727	763	3.7%
NT	1,684	1,679	1,757	1,835	1,914	3.3%
Total	**33,297**	**34,460**	**36,610**	**38,720**	**40,850**	**5.2%**

Panel C: Projected S&T gains from tax reform ($m)

State/T	2003-04	2004-05	2005-06	2006-07	2007-08
NSW	0	114	89	320	621
VIC	139	238	169	328	562
QLD	534	666	471	618	820
SA	106	131	111	166	236
WA	162	229	173	242	360
TAS	75	84	75	97	119
ACT	40	45	41	52	71
NT	115	114	106	111	118
Total	**1,171**	**1,620**	**1,234**	**1,934**	**2,906**

NSW alone required a $46m "top-up" in 2003-04 as GST revenue fell short of the guaranteed minimum amount.

Figure 2: Budget paper No 3, 2004-05

Comparison of Federal Health spending on Public Hospitals with Grants to States

COMPARISON OF FEDERAL HEALTH SPENDING ON PUBLIC HOSPITALS WITH GRANTS TO STATES

Panel A: Federal Health spending on public hospitals, source AIHW ($m)

State/ Territory	1997-98 estimated	1998-99 estimated	1999-00 estimated	2000-01 estimated	2001-02 estimated
NSW	1,911	2,305	2,411	2,628	2,768
VIC	1,354	1,662	1,728	1,867	1,992
QLD	1,016	1,147	1,181	1,302	1,388
SA	619	573	673	669	696
WA	577	640	667	688	779
TAS	171	151	152	163	174
ACT	97	86	94	103	103
NT	91	86	72	76	81
Total	**5,836**	**6,650**	**6,978**	**7,496**	**7,981**

Panel B: Commonwealth Government health care grants to S&Ts ($m)

State/ Territory	1997-98 estimated	1998-99 estimated	1999-00 estimated	2000-01 estimated	2001-02 estimated
NSW	1,618	1,863	1,999	2,121	2,249
VIC	1,118	1,336	1,435	1,522	1,623
QLD	937	1,023	1,076	1,152	1,245
SA	506	467	506	533	567
WA	530	557	570	599	661
TAS	148	125	130	137	146
ACT	80	70	72	79	84
NT	88	79	64	69	74
Total	**5,024**	**5,521**	**5,852**	**6,212**	**6,649**

Panel C: Ratio B/C

State/ Territory	1997-98 estimated	1998-99 estimated	1999-00 estimated	2000-01 estimated	2001-02 estimated
NSW	85%	81%	83%	81%	81%
VIC	83%	80%	83%	82%	81%
QLD	92%	89%	91%	88%	90%
SA	82%	82%	75%	80%	81%
WA	92%	87%	85%	87%	85%
TAS	86%	83%	85%	84%	84%
ACT	83%	81%	77%	77%	82%
NT	97%	92%	89%	91%	92%
Total	**86%**	**83%**	**84%**	**83%**	**83%**

Figure 3: Comparison of Federal Health Spending on Public Hospitals with Grants to States

EXPLANATORY NOTES

PUBLIC POLICY DILEMMAS

a) "OTHER PEOPLE'S MONEY"

In order to understand why public hospitals constantly struggle to meet demand it is important to at first identify what happens to human behaviour when the use of a service is divorced from the payment of that service.

The following diagram shows the various outcomes depending on who is spending whose money on whom.

You are the spender in this diagram

Whose money?	On whom spent	Result
Your money	Spent on you	Strong incentive to economise (price/value surveillance) and get as much value for each dollar you do spend = **Category 1**
Your money	Spent on someone else	Same incentive to economise as in Category 1 but lesser incentive to get full value for your money at least as judged by the tastes of the recipient. If there was the same incentive the spender would give the recipient the cash to purchase and hence change the situation to a Category 1 = **Category 2**
Someone else's money	Spent on you	No strong incentive to keep down the costs but strong incentive to get full value e.g. dining out on an expense account = **Category 3**
Someone else's money	Someone else	Little incentive to economise or obtain high value e.g. paying for someone else's lunch on an expense account = **Category 4**

(Reference: Free to Choose, M & R Friedman pp 116,117)

The policy implications of the above diagram are obvious when we look at how Healthcare is financed.

Category 1
A patient requests treatment from a Healthcare provider for which no Medicare rebate is payable.

The patient will be acutely aware of the cost of the service and is likely to educate themselves as to the best possible market price given the expectations of the treatment. i.e. this could be anything from cosmetic surgery to visits to an alternate therapist or independent professional such as a Psychologist.

Category 2
This category is not strongly represented in the health care system. It is not known how much expenditure would be incurred in this category but undoubtedly within families and communities there is financial support for some health care expenses.

Category 3
This category is best illustrated where you are a compensable patient and all your medical and hospital treatment costs are covered by third party funders for whom you have made no contribution. You will have no incentive to rationalise treatment costs since you have no ownership of the process. You have a strong incentive to ensure that you get maximum benefit since "it's all been paid for". This does not mean that you are acting immorally or unethically. You will not be made aware of any costs since it is not considered to be any of your business. In fact you are part of "the system".

Category 4
This is the situation for most of us observing expenditure on health care. It's what we call "free health care" Although we pay our taxes and may pay our health fund premiums, the linkage is very loose. Many health fund members feel cheated if they have the hospital or medical treatment episode of which the cost is far less than what they have paid in. Rather than say, "I've paid into a health fund for 20 years and have never made a claim, isn't it great that I haven't been sick and think of all the sick people I've subsidised. We tend to say, "I've paid into a health fund for 20 years and have never made a claim, I've wasted my money. In retrospect, I shouldn't have been a member. We care a lot about the taxes we pay but we have little incentive to care about what these taxes and premiums are paid on.

Category 3 & 4 expenditure also suffers from the problem that there is an additional party with a strong incentive to protect its interests. Those who would administer the spending on our behalf are generally paid as part of that expenditure. The connections between the contributors (taxpayers) and the spenders (legislators and administrators) is very indirect.

Administrators are spending someone else's money on someone else. Undoubtedly there are public and non public administrators who take an extremely strong "public benefit position" on expenditure decisions. But there is very little incentive to do so and spending programmes falling into this category are noted for their wastefulness and cost explosion let alone substantial benefits being diverted to the administrators.

What does this mean?
Since there is no direct customer/supplier relationship in our public hospital system there is maximum incentive to demand high quality at zero prices. Hence, there is no relationship between the funding of the hospital and the user demand, which is supposed to be met by that funding. Furthermore, State Government ownership of our public hospitals has given us the worst public policy position. Whereas once hospitals were considered community facilities with local boards and community fundraising support (charities) they are now considered government hospitals owned and run by distant faceless hospital administrators on substantial taxpayer's salaries.

b) "THE BETTER THINGS GET THE WORSE THEY BECOME"

This dilemma is well known to public policy makers. It can clearly be seen in areas like public transport.

In order to relieve congestion on the roads taxpayers invest millions of dollars in creating a more

efficient public transport system. They provide incentives to use public transport and leave their cars at home. Initially, the policy works and people start to fill up the trains, deserting the roads.

As they commute to work in crowded trains they notice out the window drivers speeding along the less crowded roads in their comfortable motor cars listening to their CDs and looking decidedly relaxed.

By improving public transport, private transport has become more attractive. Sooner or later a considerable number of new train travellers will perceive the value of car travel to have improved and will drift back to the roads to a point where they again become crowded.

Meanwhile the taxpayer has invested in improvements in public transport for no net gain in revenue i.e. public transport costs have increased whilst passenger numbers have not.

What does this mean?
The same dilemma applies to public hospitals. Since there is not direct price mechanism (market) as the public hospitals improve and waiting times decrease more people who have private health insurance or use private hospitals or non public methods of treatment perceive that the value of utilizing the "free" public hospital system has increased and demand for public services grows swamping previous improvements. What will not decline to previous levels are costs. Hence the more public hospitals are improved, the more demand there will be for public services unless a price mechanism is added and/or rigid entry criteria enforced.

WHY RISING COSTS AND FALLING PRODUCTION? - GAMMONS LAW IN ACTION.

The dilemma of greater and greater demands for public hospital financing co-existing with less and less production (beds closing as population grows) has been observed by none other than the US economist Milton Friedman:

"*Since the end of World War II, the provision of medical care in the United States and other advanced countries has displayed three major features: first, rapid advance in the science of medicine; second, large increases in spending, both in terms of inflation-adjusted dollars per person and the fraction of national income spent on medical care; and third, rising dissatisfaction with the delivery of medical care, on the part of both consumers of medical care and physicians and other suppliers of medical care.*"[23]

Friedman examined the US Healthcare spending and was not satisfied that the escalating cost of health care could be explained by increases in medical technology.

He concluded *"Two simple observations are key to explaining both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party – an insurance company or employer or governmental body. The second is that nobody spends somebody else's money as wisely or as frugally as he spends his own. These statements apply equally to other OECD countries."*[24]

Friedman explains clearly why rationing is an essential element of our public hospital system.

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[23] How to cure health care – Milton Friedman
[24] How to cure health care – Milton Friedman – The Public Interest Winter 2001

"Legislation cannot repeal the non-legislated law of demand and supply. The lower the price, the greater the quantity demanded; at a zero price, the quantity demanded becomes infinite. Some method of rationing must be substituted for price and that invariably means administrative rationing."

Furthermore, third party payment, either by health funds or by government, has led to the development of a bureaucratised system and bureaucratized systems have their own unique way of behaving. *"Third-party payment has required the bureaucratization of medical care and, in the process, has changed the character of the relation between physicians or other caregivers and patients. A medical transaction is not simply between a caregiver and a patient; it has to be approved as "covered" by a bureaucrat and the appropriate payment authorized. The patient, the recipient of the medical care, has little or no incentive to be concerned about the cost – since it's somebody else's money."*

British physician Dr Max Gammon made some important observations when he examined the British National Health System in the 1960s. Essentially Dr Gammon was trying to find out why it wasn't working. His study drew him to the pronouncement of what is now known as "Gammon's Law", or "the theory of bureaucratic displacement".

Gammon's Law says *"in a bureaucratic system increases in expenditure will be matched by a fall in production ...bureaucratic systems act like black holes in the economic universe, simultaneously sucking in resources, and shrinking in terms of 'emitted production'"*.

Evidence of the existence of Gammon's Law was not difficult to find. In the US Friedman discovered that from 1929 to 1940 the number of occupied hospital beds in the United States per resident rose at the rate of 2.4% per year and the cost of hospital care adjusted for inflation at the rate of 5% per annum. The cost per patient adjusted for inflation rose at 2% per annum.

Comparing this with post-war figures it can be seen that the number of hospital beds per 1000 of population fell by more than 60% between 1946 and 1996 whilst hospital personnel per occupied bed multiplied nine-fold and cost per patient day adjusted for inflation rose forty-fold (from $30.00 (1946) to $1200.00 (1996) at 1992 prices).

Whilst critics of Gammon's Law point to the advance of medical technology as being the main cost-driver of accelerating costs of medicine, they are at a loss to explain why other industries, which have had similar technical revolutions, have not experienced the same dramatic increase in unit costs.

The answer, Friedman concludes, is Gammon's Law. As 'soft' government money flows into a bureaucratic system there are no shortage of takers and as costs escalate greater regulation is imposed, hence, increasing administrative costs and bureaucratising the system.

Public health is not the only area where Gammon's Law is operating. Public education has also experienced substantial increases in unit costs with growing dissatisfaction.

In Australia the overwhelming trend is for parents to move from "free" public schools to direct user-pays "non-government" schools because of perceived problems with the quality of the output in public education.

In summary Gammon's Law explains why our public hospitals cannot be cured by massive injections of tax-payers funds. There must be substantial structural reform if we are to meet the reasonable expectations of public hospital users without overburdening tax payers.

MY RIGHT TO PUBLIC HEALTHCARE

One of the most noticeable changes in the development of state funded medical and hospital care has been the change in attitude of patients towards the providers of health care. Our forebears lived at a time when health care institutions were predominantly charitable for many people. Neither the American Declaration of Independence nor the Australian Constitution asserts that health care is a right.

"The term "rights," note, is a moral (not just a political) term; it tells us that a certain course of behaviour is right, sanctioned, proper, a prerogative to be respected by others, not interfered with – and that anyone who violates a man's rights is: wrong, morally wrong, unsanctioned, evil."

"According to the Founding Fathers, we are not born with a right to a trip to Disneyland, or a meal at McDonalds, or a kidney dialysis (or with the 18th century equivalent of these things) We have certain specific rights – and only these. Why only these? Observe that all legitimate rights have one thing in common: they are rights to action, not to rewards from other people."[25]

Australia does not have a declaration of rights but it does have a strong rights ethos.

Our Australian forebears had strong public views about reliance on government.

"We are threatened by the dry-rot of social and political doctrines which encourage the citizen to lean on the State, which discourage thrift, which despise as reactionary those qualities of self-reliance which pioneered Australia." [26]

This is not to say that our forebears felt no compassion for the sick

"The country has great and imperative obligations to the weak, the sick, the unfortunate. It must give to them all the sustenance and support it can."

"To every good citizen the State owes not only a chance in life but a self-respecting life."[27]

Compare and contrast these statements with the most recent observations of the Royal Hobart CEO, Ted Rayment:

"We are also witnessing the increasing expectations of patients to participate in decision making associated with their treatment and to be fully appraised of circumstances as they unfold. The patients and the community will become more aware of the need to prioritise services to match the available resources. There is a growing understanding that hospitals are health service providers and, as a service industry, have customers who have rights and expectations against which our service will be assessed."[28]

Hence public hospital treatment has now not only developed the status of an inalienable right. Many being treated by the system consider themselves to be paying customers demanding all of the service delivery that they would at an expensive hotel.

This cultural change has come about not by public demand. It has been shaped by public policy makers, politicians and administrators who have turned the patient into a consumer and doctors and nurses into health care providers. In brief, it has created a consumer expectation which can never be met from the public purse.

To restore public confidence in our public hospital system there will need to be a significant cultural change which confronts unrealistic expectations. Public hospitals have never been able to meet all expectations of all people. Given an opportunity they may meet the reasonable expectations of reasonable people who need to be looked after in a public system.

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[25] Health Care Is Not a Right, Leonard Peikoff, 11 December 1993

[26] "The Four Freedoms" Freedom from Want, Robert G Menzies, Radio Broadcast 10 July 1942

[27] "The Four Freedoms" Freedom from Want, Robert G Menzies, Radio Broadcast 10 July 1942.

[28] Message from the Chief Executive Officer, Royal Hobart Hospital, Ted Rayment, 9 April 2003

THE HISTORY OF PUBLIC HOSPITALS

Today's public hospitals owe their origins to the desire by religious people and reform movements who are highly motivated to show practical compassion for the sick, needy and destitute.

The parable of the Good Samaritan is a clear example of Christian teaching emphasizing compassion for suffers including those outside ones family or tribal circle.

An account of Fabiola, a pious woman who founded one of the first examples of a Christian hospital in Rome in 390 AD says as follows:

"She sold all that she could lay her hands on of her property, and turned it into money she laid out for the benefit of the poor. She was the first person to found a hospital, into which she might gather sufferers out of the streets, and where she might nurse the unfortunate victims of sickness and want. Need I now recount the various ailments of human beings? Need I speak of noses slit, eyes put out, feet half burnt, hands covered with sores? Or of limbs dropsical and atrophied? Or of diseased flesh alive with worms? Often she would carry on her shoulders persons infected with jaundice or with filth. Often too, did she wash away the matter discharged from wounds which others, even though men could not bear to look at. She gave food to her patients with her own hands, and moistened the scarce breathing lips of the dying with sips of liquid."[29]

The church's involvement was reinforced by the Christian duty as proclaimed by the church to look after the homeless.

In Europe shelters created by charitable organisations to care for displaced persons became linked to major churches. These later developed into hospitals with names like St Bartholomew's founded in London in the 12th century.

By the 18th century cities like London were spawning more secular charitable institutions with church linkages. These charities had a strong voluntary ethos and this movement was responsible for the growth of public institutions specifically designed to treat the sick poor since the wealthy were considered to have access to general practitioners, usually visiting their homes for treatment.

Specialist hospitals had emerged in the 17th century in Europe for patients with infectious diseases such as leprosy and syphilis. Although some general hospitals such as those in France housed everyone including prostitutes, the poor and the insane.

The move to secular administration of public hospitals was enhanced in France by the French Revolution (1789-1799), where the State seized the property of the church, hence "*So reform of hospitals as a responsibility of the State, is an invention of the French Revolution. Other parts of Europe did have State-supported hospitals, like the Austrian Empire, but they were still involved closely with religious affairs as well as medical affairs. The pure secularized version of the hospital is an outcome of the Revolutionary period.*"

As public hospitals aggregated patients and their pathology, it became obvious that they should develop into centres of research and teaching as well as providing public welfare. Dr Gunter Resse, Professor of History of Medicine at the University of California in San Francisco, studied patient records in the 18th and 19th century at the Royal Infirmary in Edinburgh.

His research shows that for this hospital the patients admitted were young, of both sexes, and considered to be "the deserving poor", i.e. they had a job and were not vagrants. They came

[29] The Health Report – Hospitals and Hospitality (Pt ½) – 16 February 1998

voluntarily to the infirmary with a letter of introduction from a hospital subscriber. The subscriber was a financial supporter of the hospital who had a right to grant letters of subscription.

Hence, patients came on a referred basis. They had insurance of sorts because their boss or someone they knew was a subscriber to the hospital and they had a disease which was curable.

Wards in the infirmary had between 12 and 24 beds. Patients were given clean clothes and were fed three meals a day. There was a doctor for each ward and a clerk to take care of the admission cases.

Professors from the university nearby came and did grand rounds at midday for an hour with their clerks and the house physicians. Medical students wanting to attend the grand rounds had to buy a ticket.

Nursing standards were poor because the nurses were mainly domestic servants or ex-domestic servants who had been fired by their previous employers. They often asked for additional "bribes or presents" and patients had to be on the right side of them.

Although treatment was primitive patients got beer every day and wine was often prescribed.

With the development of the germ theory of disease by Koch Pasteur, Lister and Semmelweis, hospitals changed substantially as antiseptic conditions were enforced and the knowledge that infectious disease could be contained.

As medicine progressed it became apparent to many patients that many of their medical conditions could actually be cured. Hence, demand to be treated at the Royal Edinburgh Infirmary by the famous Dr Joseph Lister turned the wards of the hospital into "chaotically overcrowded places."

In response to the overcrowded conditions patients had to sleep two to a bed after they received their operation, with some patients left to find a room in any bed for themselves.

The arrival of the new Nightingale Nurses in the late 1870s brought some order to this chaos at the Edinburgh Infirmary. The nurses were trained at St Thomas's hospital and implemented the new antiseptic medical treatment protocols. The emphasis was on getting people well and out of hospital.

By the end of the 19th century almost all major hospitals in Europe and America had training schools for nurses attached to them.

The arrival of good nursing care attracted further demand, this time from middle class patients who saw that by going to hospital they could be better looked after than staying at home, and they were prepared to pay for it. With the advent of X-ray machines and other important items of medical hardware it became obvious that treating patients with acute conditions at home was totally impractical. The hospital was the place to be. Hence, demand grew.