Additional comments

Senator Scott Ryan

In recent years, as State Public Hospital systems have fallen further behind the standards expected of them, arguments in favour of greater centralisation of health policy and funding in Australia have become more prominent. These arguments have usually advocated the Commonwealth taking complete control of and responsibility for Australia's health sector.

This argument for national control reflects an assumption that central control of health would in some way deliver better outcomes. Yet little or no evidence to support this claim is offered.

The sentiment that "Canberra knows best" or "Canberra does best" also undervalues the tensions inherent in a federal arrangement that have served to develop and support Australia's complex health system, including those elements that are successful.

One of the core benefits of a federal approach in contrast to a uniform, single national approach is that of policy trial and comparison.

Varying management and funding regimes in operation across the states have allowed for different policy responses to the funding and resource pressures inevitable in public hospital systems, particularly one with low or no price signals at points of access.

The ability of state-managed hospital systems to trial various policy responses to these challenges are obvious from a cursory glance at our public hospital system.

The most successful of these has been in relation to the method of funding hospitals. Activity-based funding ('casemix') was introduced in a significant fashion in Victoria's hospital system by the Kennett Government in the mid 1990s. The rationale behind the introduction of casemix funding was to drive hospital behaviour by rewarding performance and efficiency.

The political opposition to this change at the time of its introduction should not be underestimated. Doctors, unions and, most notably, the then State Opposition Leader Mr John Brumby, consistently attacked the introduction of casemix funding, arguing it would reduce patient care. Only fifteen years later, it is argued that this model, first introduced in Victoria, would dramatically improve patient care if implemented across Australia.

With the significant opposition of vested interests to such reforms, it is highly doubtful that such a dramatic reform could or would have been implemented at a national level. There is no evidence to suggest that the ability to challenge vested or provider interests is greater from the distance of Canberra than our state capitals, problematic though the behaviour of the latter has been this past decade.

The Rudd Government's so-called health reform package, more accurately titled a hospital administrative and spending package, illustrates the problems of inertia in any large government-run system. As funding is dominated by the inertia of past practice, large institutions and the loudest voices, the opportunities for radical or substantial reform, particularly those that challenge provider interests, is diminished. This is exacerbated by moving from state-run systems that may vary across the country to a single, national approach.

As the Kennett casemix funding reforms have proven successful, the differences between the public hospitals in Victoria and other states have become more apparent. Although I hasten to add that most Victorians would be surprised and concerned to hear that the state of Victorian hospitals is apparently a benchmark for national reform, as Victorian hospitals do not meet the needs of the Victorian community.

Determining a single, national model for hospitals may well ensure that the next wave of reform is stifled. The more nationally-dominated and controlled our health system is, the less capacity for a single jurisdiction to undertake a reform program akin to that implemented by the Kennett Government in Victoria.

It should be noted that in health the most significant area of influence by vested interests in public hospitals relates to labour costs. The increase in labour costs has been a major factor in the dramatic increase in health spending over the past decade.

One of the great benefits of a federal approach and differing regimes is limiting the ability of capture by vested interests. In terms of public sector service provision this risk is magnified.

As the major element of recurrent health budgets, restraining growth in labour costs is a critical part of driving efficiency in our health system. In this regard, the states have particularly failed over the past decade as they have become further captured by public sector provider interests at the expense of the interests of consumers and taxpayers.

There is no evidence to suggest that this would in any way be addressed by a more centralised arrangement. Indeed, the removal of varying jurisdictions' responsibility for labour agreements would simply increase the risk of capture by provider interests as the number of responsible governments would be reduced from eight to one.

Furthermore, the balance of responsibilities that exist in our health system has served it well in two respects.

First, the inability of a single jurisdiction to impose its own preferred model of health policy has prevented a government imposing a policy that does not have some degree of consensus wider than the governing party. As many of the views in the health policy debate represent those of different providers, and the genuine consumer voice is rarely if ever heard, this limitation on the power of one government to act should not always be seen in a negative light.

Second, ongoing political pressure from elections in different jurisdictions has ensured a constant and ongoing accountability for health policy. Health is an issue at every state and federal election - this ongoing political pressure is removed if a single level of government has unilateral responsibility.

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