

# Prime Minister Rudd's plan for reforming Australian public hospitals

David G Penington

*It is the long term that matters — not a quick fix*

Kevin Rudd's election commitment in November 2007 to take over the funding of public hospitals and fix them has led to a bold and courageous plan,<sup>1</sup> unveiled after a 15-month review by the National Health and Hospitals Reform Commission (NHHRC) and further extensive consultations. Some pillory the delay, but with such a complex system and so much at stake, caution is admirable. The real questions are whether the solution offered on 3 March 2010 for public hospitals<sup>1</sup> will work, and what problems will it solve? Further debate is urgently needed.

The NHHRC report<sup>2</sup> had worthy features and intentions, but fundamental flaws as a basis for reform. Public hospitals must be seen in the wide context of health care, not in isolation. No doubt further statements on primary care and prevention are to come, but the 3 March statement only covers hospital reform. Many unanswered questions remain.

What were the serious flaws in the NHHRC report and do they matter?

First, the report saw health care as a series of silos with separate control, regulatory processes and funding streams covering public hospitals, primary care, aged care, mental health, health workforce education, preventive care, research, quality and safety oversight, and so on, when the imperative is to bring all these to effectively overlap and intertwine at the local level. This is what the community needs.

Second, it saw control of public hospitals, as developed over the past 15 years, as a matter of external numerical control of "casemix" numbers and budgets, and regulation based on waiting lists and waiting times in emergency services. The disasters in Bundaberg<sup>3</sup> and at the Royal North Shore Hospital,<sup>4</sup> and even in the trauma unit at the Alfred Hospital in Melbourne,<sup>5</sup> all occurred in hospitals performing well on numbers and budgets!

Third, the report paid little attention to clinical governance. Good and safe care, research and development, so the best care is offered to all, and good education of health professionals (the investment for future care) depend on professionals taking pride in the quality of services offered. This is a powerful resource if wisely used. Clinical governance is needed to secure safety and quality when difficult judgements have to be made every day in caring for acutely ill patients. Some mistakes are inevitable. Involvement of professionals with management is vital. External agencies based in Canberra, or even state departments, cannot deliver this.

Finally, its consideration of aged care did not focus on the critical community sector. The escalating costs of an ageing population will create huge problems, as shown in the Treasury's *2010 Intergenerational report*.<sup>6</sup> However, care of older people does not belong in Canberra, as recommended by the NHHRC. Every sector needs to work together to keep people at home as long as possible, supported by good e-health, using community nursing

and local pharmacists, as well as general practitioners, subacute (rehabilitation) hospitals and nursing homes. These institutions are far cheaper to build and operate than acute hospitals. Acute hospitals have large numbers of older people in beds, blocking elective surgery and supporting emergency care.

Devolving national responsibility for hospital management all the way to small Local Hospital Networks, with Australian Government performance indicators and casemix funding of 60% of "efficient costs",<sup>1</sup> will leave many hospitals in dire straits in those states where unit costs are far higher than in Victoria (the model for casemix funding). States will have to pick up the tab for much more than the 40% envisaged in order to keep many hospitals solvent. Even in Victoria, there are 40 regional hospitals that have to operate on block grants because casemix cannot adequately recognise services they need to provide for their communities. There will be a need for continuing state health department roles to supplement a new federal health bureaucracy in every state, with the Local Hospital Network boards having to respond to both. The NHHRC thought it had ended the "blame game", but with two tracks for funding and decision making on every issue, including major equipment, hospital capital and maintenance, let alone separate tracks for the many aspects of aged care, there is huge potential for blame shifting.

I urge devolution to larger regional clusters, each built around a public university with a Faculty of Medicine and Health Sciences, which can bring understanding of the roles of the professions. These would have the capacity to build an interface between hospitals and primary care, and to integrate the role of nurses — not only in hospitals but in community care of older people — and of physiotherapists, who have much to offer in rehabilitation and aged care, especially as cheaper subacute (rehabilitation) hospitals are developed.

The prime role of the Department of Health and Ageing in Canberra should be policy. The regional clusters should represent a tripartite relationship between federal government, state government and university, with the state health minister having a role in governance and in coordination of statewide services. The clusters would then be the one-stop shop for major decisions, and blend the several streams of funding. Clusters should be free to contract for services from either the public or the private sector on the basis of cost and quality, and major hospitals across the country should become incorporated entities competing for contracts, with incentives to control burgeoning administrative staff numbers. The system would take several years to settle down, but it is the long term that matters — not a quick fix.

Details of the model proposed here can be found at [http://www.grattan.edu.au/publications/011\\_penington\\_health\\_cluster\\_proposals.pdf](http://www.grattan.edu.au/publications/011_penington_health_cluster_proposals.pdf).

## Competing interests

None identified.



## VIEWPOINT

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### References

- 1 Rudd K. Better health, better hospitals: the national health and hospitals network. Speech to the National Press Club, 3 March 2010. <http://www.pm.gov.au/node/6534> (accessed Mar 2010).
- 2 National Health and Hospitals Reform Commission. A healthier future for all Australians: final report June 2009. Canberra: Department of Health and Ageing, 2009. <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhhrc-report-toc> (accessed Mar 2010).

- 3 Van Der Weyden MB. The Bundaberg Hospital scandal: the need for reform in Queensland and beyond [editorial]. *Med J Aust* 2005; 183: 284-285.
- 4 Joseph AP, Hunyor SN. The Royal North Shore Hospital inquiry: an analysis of the recommendations and the implications for quality and safety in Australian public hospitals. *Med J Aust* 2008; 188: 469-472.
- 5 Ombudsman Victoria. *Whistleblowers Protection Act 2001* report of an investigation into issues at Bayside Health [parliamentary report]. 29 October 2008. Melbourne: Ombudsman Victoria, 2008.
- 6 Australian Government Treasury. The 2010 intergenerational report. Canberra: Commonwealth of Australia, 2010. <http://www.treasury.gov.au/igr/igr2010/> (accessed Mar 2010).

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