

7 Health

Introduction: The Problems in Context

For nearly twenty years now, health has been the most difficult public policy problem facing Australian governments, both State and Federal. Demand is apparently boundless; vested interests proliferate; problems of inefficiency and unaccountability afflict supply; irrational considerations of ideology make rational policy discussion almost unattainable.

The problem, moreover, will get worse. While it is comforting to know that many treatments, surgical or otherwise, get shorter and safer, the necessary technology tends to get more expensive. And health care, like income security, involves generational considerations: expenditure on each citizen grows dramatically as the citizen gets older, a considerable problem as our population ages.

Looking at overseas experiences gives little cause for encouragement. No comparable country has a long-established total health system which comes anywhere near perfection, or which offers a ready-made model for transplanting to Australia. And looking at other countries offers us, in fact, a hypothesis that would make any self-respecting treasury official despair: expenditure on health tends to increase as nations and their citizens get wealthier—health spending becomes a 'positional good', like spending on leisure or any other 'quality of life' good.

None of this should discourage us from defining and pursuing the basic policy task, which is, in essence, to deliver in the most efficient manner possible the combination of quality and quantity of service decided on by some properly accountable means within the funds decided on by the political process.

Even by that broad essential definition, Australian health policy is not to be judged a notable success.

Expenditure, both as a proportion of the Commonwealth Budget and as a percentage of national product has steadily increased over the last twenty years: from 10.5 per cent of the Budget in 1972 to 13.4 per cent in 1992, and from 5.9 per cent of GDP in 1972 to 7.7 per cent in 1992. Evidence of apparent unmet demand is everywhere in the form of patient queues. There is at the same time considerable spare capacity in many public and private hospitals. Accountability is poor: good and current information on both costs and quality is not easily accessible to the general public or to professional enquirers. From what is available, however, it is clear that efficiency and quality vary greatly across the country.

The Federal government's policy responses to continuing difficulties include price control, and controlling the number of providers. The private hospital sector is implicitly discouraged from major new initiatives, although it may be permitted a peripheral, even 'last resort', role. The potential role of private health insurance in relieving pressures has so far been explicitly rejected. Public debate about the problems has been acrimonious; over the last year the Federal government has countered State requests for more money for the public hospital system with arguments that efficiency improvements within State hospitals would release hundreds of millions of dollars.

This last matter brings us to the starting point of our own study of health services in Western Australia. The State government—*any* State government—operates within the constraints—ideological and financial—imposed by the Federal government. The price of accepting Commonwealth funding for the State hospital system is free treatment for Medicare patients in public hospitals. Since the 1992 Federal Budget, the strings attached to the Medicare funding have become tighter, and now, for instance, include a requirement that the States pass legislation which entrenches the principles of Medicare. At the time of writing, the outcome of the protracted post-Budget negotiations was still far from clear; it seemed likely that a shift in the overall political balance among the State governments might force a result more rational than was the case in August.

These constraints severely limit the ability of the State government to find better ways of running a more efficient and accountable hospital system. Fully-fledged privatisation, for instance, would seem to be ruled out. A very courageous government might try going it alone on public hospitals, and indeed one health economist has

suggested a method of doing just that.⁸⁷ It is something that should be considered by a new State government; in this chapter we will concentrate on approaches more clearly within the limits of political possibility.

A complicating factor is that, with a change in government possible at the next Federal election, there may be a fundamental change in overriding health policy; at least to the extent that a new Federal Minister for Health might be willing to contemplate new arrangements within individual States. We believe that our suggested approaches will fit in with any likely policy changes in Canberra, and that the principal model suggested will deliver a better hospital system under any likely Federal regime. A first recommendation, however, should be made here: the new State government should seek, together with its counterparts in other States, a more rational funding arrangement with the Commonwealth.

The focus of this chapter is very much on hospitals. The maintenance of the public hospital system is, of course, only one of the Department's functions. It also provides the normal policy, monitoring and administrative functions; community health facilities; nursing homes; psychiatric facilities; alcohol and drug services; school dental services; and a good deal of public health propaganda. Some of these will be the subject of comment at a later stage. But since hospitals account for over 85 per cent of the State's health budget, it is sensible to focus on them.

Health, indeed, is the second biggest item in the State Budget. At \$1271 million, it represented 16.5 per cent per cent of outlays in the most recent State Budget. This in itself makes it an obvious candidate for scrutiny. Experience and theory suggests other more compelling reasons. Most of the State's hospital care is provided at no immediate cost to the consumer by organisations with near-monopoly status controlled, directly or indirectly, by bureaucrats and providers. We would reasonably expect the system to display certain characteristics common to such arrangements, including:

- indiscriminate overprovision;
- severe problems with resource allocation;
- lack of control over costs;
- poor product information for consumers;
- defective quality control;

⁸⁷ See J. Logan, 'Public Hospital Funding: An Exercise in Political Monopolisation', Health & Welfare Policy Programs, Working Papers Series No. 2, Centre for Independent Studies, Sydney, December 1988.

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- lack of accountability;
- openness to pressures from politics and vested interest;
- bureaucratic expansionism; and
- credentialism.

All of these appear to be present, although they may not have been officially diagnosed as such.

Many can be identified as implicit in the numerous publications of the National Health Strategy Unit over the last two years. The Federal Minister has certainly established to his satisfaction the existence of unspecified 'inefficiencies' in the State systems. The last State government itself commissioned, in January 1991, the Metropolitan Health Services Review, whose terms of reference explicitly asked for better efficiency and effectiveness, including considerations of accountability, resource allocation, and management. Anecdotal evidence, of course, abounds.

The difficulty for the outsider—a very considerable difficulty—lies in trying to locate the inefficiencies, given the very poor quality of the available data. (Since the publication of the Royal Commission's two reports, accountability has been brought to the fore in political debate. This might be a good place to suggest that one useful subsidiary definition of accountability is the publication of enough data to enable the construction of satisfactory policy alternatives.)

An initial, broad, judgement can be made on the basis of the comparative material published annually by the Commonwealth Grants Commission. The following table compares the State's actual expenditure, per capita and in constant dollars, on general medical services with the all-State average, adjusted for Western Australia's peculiar social and geographic circumstances.

| | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 |
|--------------|------|------|------|------|------|------|------|------|------|------|
| Standardised | 314 | 317 | 319 | 424 | 433 | 451 | 472 | 471 | 471 | 478 |
| Actual | 379 | 374 | 389 | 472 | 477 | 487 | 488 | 503 | 505 | 519 |
| % over-spend | 21% | 18% | 22% | 11% | 10% | 8% | 3% | 7% | 7% | 8% |

Source: CGC data *Note:* Years refer to fiscal years (e.g., '1982' refers to 1981/82)

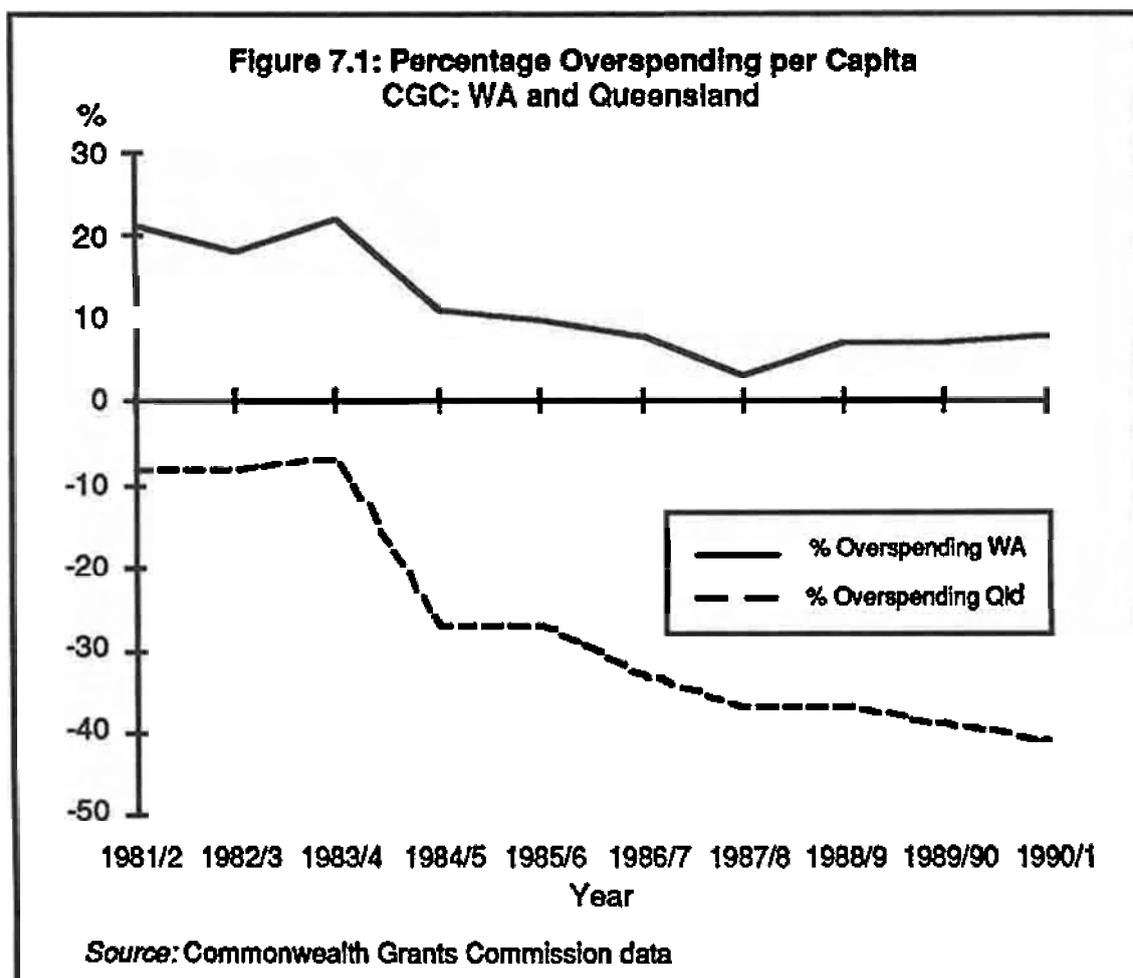
The table shows that, using the reasonable index established by the Grants Commission, Western Australia has for some time now been spending somewhat more on its public health system than it need. The next table is perhaps even more useful: it shows the same comparison, actual against standardised, for Queensland.

Table 7.2: Commonwealth Grants Commission: QLD (1984-5 prices)

| | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 |
|----------------------|------|------|------|------|------|------|------|------|------|------|
| Standardised | 306 | 308 | 310 | 406 | 414 | 432 | 459 | 458 | 458 | 465 |
| Actual | 282 | 284 | 290 | 320 | 325 | 325 | 334 | 333 | 328 | 330 |
| % <i>under-spend</i> | 8% | 6% | 7% | 27% | 27% | 33% | 37% | 37% | 39% | 41% |

Source: CGC data *Note:* Years refer to fiscal years (e.g., '1982' refers to 1981/82)

The data for the two States can be brought together and expressed graphically:



A few other figures relating to the public hospital sector in Western Australia and Queensland will reinforce the comparison. In 1989–90, the cost per occupied bed day in Queensland was \$429, the cost per separation \$2449; the same costs in Western Australia were \$515 and \$3026 respectively.

There is no reason to believe that Queensland's public health services are in any way worse either than those of most States or those of Western Australia. (One fairly coarse measure of adequacy can be found in State-by-State levels of private health insurance: Queensland has the lowest level of private insurance in Australia.⁸⁸) If Queensland can maintain this unexceptionable level of service by spending less than its standardised figure and less—far less—than Western Australia, then it is virtually impossible to escape the conclusion that Western Australia overspends and spends in a way which, *prima facie*, appears to be very inefficient. The first table also shows that per capita spending on public health (not hospitals as such) has been rising steadily.

(A note of caution does need to be sounded here. While interstate comparisons are useful in many respects, not least in uncovering areas of gross discrepancy, they are not to be taken as policy prescriptions *per se*. The limitation here is not simply one of comparing very different institutional structures, with their own history and rationale; but rather that whatever usefulness cost comparisons may have is severely limited by the absence of quality comparisons.)

In the case of most States, a detailed analysis of the sources of inefficiency would not be easily possible; lack of data would prevent it. That would be the case, too, in Western Australia, if it were not for the existence of the Metropolitan Health Services Review (hereafter, MHSR).⁸⁹ The recommendations of the Review are for the most part ineffectual (reflecting political constraints); the statistical appendix, however, contains a good deal of raw data which can be made to show where some of the acute problems lie.

Three explanations are usually brought forward to explain cost pressures on our public health systems:

- excessive demand;

⁸⁸ Queensland *does* have a different history of public health provision from Western Australia. But here, as elsewhere, the discrepancy between the two levels of expenditure suggests that quality is less important a determinant than efficiency. See the comments on CGC data in Chapter 5.

⁸⁹ Metropolitan Health Services Review, Final Report to the Government of Western Australia by Deloitte Ross Tohmatsu, Perth, December 1991.

- increases in capital costs; and
- increases in equipment and drug costs.

It is worth looking at each of these in turn.

In the absence of a freely-operating market, *demand* is somewhat difficult to measure; indeed with an apparent price of zero, demand is perhaps meaningless. More or less reasonable substitute measures have to be found elsewhere. We can look at the throughput of hospitals, as found in the number of patients discharged—'separations'. We can look at the intensity of treatment, at the pressure a patient places on hospital resources—bed days. On the basis of the MHSR data we can say that between 1986–87 and 1990–91, separations in teaching hospitals rose by 17.3 per cent, or 3.5 per cent per year, and bed days in teaching and non-teaching hospitals rose by only 1.5 per cent. Neither figure reveals any strong indication of excessive demand. It might be further noted that over the same period admissions increased by 14.7 per cent, or 2.9 per cent per year, another indicator of weak demand.

The argument for *capital costs* as a contributing factor is even weaker. Data from State Budgets show that real capital costs per bed day have fallen by 64 per cent between 1986–87 and 1990–91.

The two other components of costs mentioned—*equipment and drugs*—did increase. In teaching hospitals, equipment costs per bed day rose by 44.4 per cent over the period studied, and accounted for 17.8 per cent of the total rise in real costs per bed day. Equipment costs in non-teaching hospitals rose by 64.8 per cent by the same bed day measure, accounting for 8.3 per cent of the total rise in real costs. (The difference between the respective contributions to total cost increases reflects the fact that teaching hospitals are more costly to equip and operate). The real costs of drug supplies in teaching hospitals rose by 29.3 per cent by the same measure over the period, accounting for 11.4 per cent of the total cost increase. These factors therefore contributed noticeably to cost increases, but are far from being major factors.

The principal factor is one which is not much mentioned in the public debate: *labour costs*, particularly of nurses, doctors and administrators. The omission is surprising, since health is essentially a service industry, heavily dependent on labour costs.

Table 7.3: Real cost per bedday (\$): WA Teaching Hospitals

| | 1986/87 | 1987/88 | 1988/89 | 1989/90 | 1990/91 | % increase | % of total increase |
|-----------------|---------|---------|---------|---------|---------|------------|---------------------|
| Nursing | 110 | 113 | 112 | 116 | 120 | 8.8% | 21.5% |
| Medical | 62 | 63 | 62 | 72 | 76 | 22.9% | 31.6% |
| Admin | 37 | 39 | 38 | 39 | 41 | 9.9% | 8.2% |
| Total | 322 | 324 | 319 | 338 | 349 | 8.6% | 61.6% |
| Equip | 18 | 18 | 17 | 21 | 26 | 44.4% | 17.7% |
| Drugs | 17 | 18 | 20 | 21 | 23 | 29.2% | 11.3% |
| Total operating | 79 | 80 | 83 | 85 | 89 | 12.7% | 22.2% |
| Grand Total | 444 | 447 | 444 | 470 | 489 | 10.1% | 100% |

Source: Metropolitan Health Services Review (MHSR)

Once again we can make a revealing (if limited) comparison between Western Australia and Queensland:

Table 7.4: Average Salaries 1989–90 Total Public: QLD v WA

| | QLD | WA | % Difference |
|----------|----------|----------|--------------|
| Nursing | \$28,466 | \$34,052 | 19.6% |
| Medical | \$71,192 | \$75,167 | 5.5% |
| Admin | \$22,566 | \$25,503 | 13.1% |
| Hotel | \$21,792 | \$22,438 | 2.9% |
| Med Supp | \$28,342 | \$35,292 | 24.5% |
| Total | \$29,423 | \$33,067 | 12.4% |

Source: Australian Institute of Health (AIH), Hospital Utilisation and Costs study, 1989–90, preliminary data

The MHSR data show that between 1986–87 and 1990–91, the nursing salary component in teaching hospitals, in terms of real cost per bed day, rose by 8.8 per cent, and accounted for 21.6 per cent of the total cost increase in teaching hospitals. It should be noted that over the same period nursing numbers fell; so the rise is entirely due to salary increases. It should be noted that this was largely imposed by circumstances outside the State government's control: in particular the Commonwealth's support for a new national nurse wage structure. In the same terms, doctors' real wages in teaching hospitals rose by 23 per cent, accounting for 31.6 per cent of the total cost increase. In terms again of real wage per bed day in teaching hospitals, administrative salaries rose by 10 per cent; numbers increased by

13.5 per cent. We might also note that labour costs accounted for 62 per cent of the total rise in real cost per bed day in teaching hospitals, and for 72 per cent in non-teaching hospitals.

Wage costs are only a part of any full picture: in the end, of course, productivity is the most important part. As far as the data allow us to judge, there have been some minor improvements in productivity—particularly of nurses—but such benefits as have occurred have been captured by the hospital personnel rather than the taxpayer. In trying to understand productivity issues it may be useful to look at the changes in staffing over recent years:

Table 7.5: Staffing Levels per Occupied Bed: Teaching Hospitals

| | 1986/87 | 1987/88 | 1988/89 | 1989/90 | 1990/91 | % Increase |
|----------|---------|---------|---------|---------|---------|------------|
| Nursing | 1.94 | 1.88 | 1.82 | 1.83 | 1.86 | -4.0% |
| Admin | 0.74 | 0.78 | 0.79 | 0.81 | 0.82 | 11.3% |
| Hotel | 0.97 | 0.94 | 0.93 | 0.95 | 0.91 | -5.4% |
| Med Supp | 0.69 | 0.70 | 0.70 | 0.71 | 0.73 | 5.4% |
| Maintnce | 0.24 | 0.23 | 0.22 | 0.22 | 0.22 | -9.7% |
| Medical | 0.43 | 0.44 | 0.45 | 0.52 | 0.55 | 28.5% |
| Total | 5.0 | 4.98 | 4.92 | 5.03 | 5.09 | 1.8% |

Source: MHSR

And the comparison with Queensland would seem to show that Western Australia has lower productivity in the areas of administration, domestic and medical officers:

**Table 7.6: Staffing levels per Occupied bed 1989–90, QLD v WA
(Total Public)**

| | QLD | W.A. |
|----------|------|------|
| Nursing | 1.97 | 1.70 |
| Admin | 0.35 | 0.60 |
| Hotel | 0.56 | 1.05 |
| Med Supp | 0.76 | 0.47 |
| Medical | 0.22 | 0.28 |
| Other | 0.14 | 0.20 |
| Total | 4.00 | 4.30 |

Source: AIH preliminary data (HUCS)

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Looking at staffing, behind these statistics, reveals a number of problems which have been allowed to develop without any serious regard for the financial implications. One significant problem is the switch from hospital-based to tertiary education-based training for nurses. This has been the immediate cause of a particular cost factor, in that relatively poorly paid trainee nurses are no longer available for a wide range of routine hospital duties. The benefits of the switch are not clear; there are reasons for believing that the professional skills of new nurses are not as good under the new system as under the old, and the disappearance of the trainee class has left nurses without anyone to whom those routine duties can be delegated.

Another significant problem for Western Australia is the number of teaching hospitals. It is not simply that we have five teaching hospitals, which seems rather a lot to service one faculty of medicine. Expenditure on teaching hospitals in Western Australia is a higher proportion of total hospital expenditure than in any other State. At about 60 per cent of the total, it is very considerably higher than in Queensland, for instance, at about 45 per cent; and with about 40 per cent of total public beds in teaching hospitals, it is very considerably higher than Queensland's 25 per cent.

A further obvious area for examination is the staffing mix of hospitals. In 1989-90, across both teaching and non-teaching hospitals, nurses accounted for 40 per cent of staff, doctors for 7 per cent, administrators for 15 per cent, domestic staff for 24 per cent, medical support for 11 per cent and other staff for 3 per cent. Once again, it is interesting to compare this situation with Queensland's: nurses accounted for 49 per cent, doctors for 5.5 per cent, administrators for 8.9 per cent, domestic staff for 14.1 per cent, medical support for 18.9 per cent and other staff for 3.6 per cent:

Table 7.7: Staffing Mix 1989-90 (Total Public)

| | QLD | WA |
|----------|-----|-----|
| Nursing | 49% | 40% |
| Medical | 5% | 7% |
| Admin | | 15% |
| Hotel | 14% | 24% |
| Med Supp | 19% | 11% |
| Other | 4% | 3% |

Source: AIH preliminary data (HUCS)

