Is there a better alternative for Australia’s health system?

Professor Jeff Richardson
Foundation Director, Centre for Health Economics
Monash University

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Correspondence:

Professor Jeff Richardson
Centre for Health Economics
Faculty of Business and Economics
Monash University  Vic  3800
Australia

Ph: +61 3 9905 0754  Fax: +61 3 9905 8344
Email address: Jeff.richardson@buseco.monash.edu.au
This article examines three issues. These are, first, the need for the Rudd government intervention in the health sector; secondly, the reasons why system governance needs major reform despite this intervention; and, thirdly, the broad options for reform. The conclusions reached are, firstly, that the intervention is anticlimactic but necessary in the absence of tax reform; secondly, that the system is unfair, lethargic and iatrogenic, primarily because of two deficiencies, namely information and governance structures; and thirdly, that the best path to follow would be to create limited diversity and the depoliticisation of all but the largest decisions.
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1 Introduction

There is a compelling case for rationalising the Commonwealth-State division of responsibilities in the health sector and for many years there has been almost universal agreement that a single level of government should be responsible. The least serious problem is the blame shifting which presently occurs. More substantively, the divided authority between Commonwealth (medical and pharmaceutical services) State (public hospitals and community/primary care) inhibits the coordination of services and organisational innovation and diverts bureaucratic creativity into cost shifting.

The issue would not be of concern if Australia could boast an outstanding health system. But it cannot. Australians have good health but it is a logical error to attribute this to the way we organise and deliver health services. Numerous factors impinge upon health (nutrition, education, etc). The quality and number of our health professionals are important contributing factors but this does not mean that the patchwork delivery system uses them to our best advantage.

Against this background the initial Rudd government proposal to assume de facto control of the hospital sector and therefore de facto control of the health system may have appeared to be a desirable reform. In principle, the Commonwealth would have had the ability to address issues where States have proved to be ineffectual or the State-Commonwealth system has failed. But this logic is superficial. A doctor who must amputate a leg must amputate the right leg not just any leg. Likewise, system problems require appropriate action, not just any action. The creation of monopoly control over effective power, system innovation and information by an authority with a deeply flawed track record and a powerful incentive for error suppression is analogous to the surgeon amputating the good leg.

In the event, opposition from the States (primarily Victoria and WA) and the compromise agreement signed (by all but WA) at the Council of Australian Government (COAG) on April 20, 2010 (COAG 2010) prevented the government from fulfilling its election promise to ‘takeover’ control of State hospitals and thereby create a single national mega monopoly – at least in the short run. Perhaps this is to be expected in view of the Commonwealth’s inexperience in the hospital sector. Instead, the ‘intervention’ is to consist of a single substantive change in the governance, namely, cost sharing of hospital costs with 60 percent Commonwealth and 40 percent State contributions. The dollar amounts are to be calculated by DRG adjusted payment
per case with an ‘efficient’ price determined by an independent authority. Emergency and hospital outpatient costs (but not primary or community care, etc) will be included in the formula.

Monies for hospitals will be paid into separate State and Territory ‘Funds’ which will be administered by the States. Control of hospitals will not be ceded to the Commonwealth. In addition to this single structural change, the Commonwealth has announced a modest increase in hospital funding and that a series of targets will be met. The adequacy of the funding and the likelihood of achieving the targets, however, are simply assertions. There is no visible mechanism by which these improvements will be achieved or sustained.

The maintenance of State influence significantly alters the consequences of the intervention. There will now be no administrative or financial incentive for – in COAG’s words – ‘helping patients receive more seamless care across sectors of the health system’ ie between hospital and other services. Nor does anything in the announcement suggest systemic change which will improve quality. The tantalising promises made will be achieved by the old team, that is, by ‘cooperating’ State and Commonwealth bureaucrats answerable to different masters. Incentives for blame and cost shifting remain. Problems associated with hospitals may still be attributed by the Commonwealth to State management and inadequate funding by the States. States have an additional incentive to expand the supply of hospital services – especially in electorally sensitive areas – as they will only pay 40 percent of the cost, but receive all of the credit for the new facilities.

Why then has the intervention occurred? The publicly stated reason has been that it has been to overcome the problem of excessively long hospital queues which the States have failed to resolve alone.

Queues (and the unmeasured queues of those waiting to get onto queues) in State hospitals are undesirably long. However, no conclusion can be drawn from this single fact which explains the attempted takeover of control or the present structural change. Queues are the outcome of demand and supply where supply depends upon the availability of doctors (a Commonwealth responsibility), nurses (a Commonwealth responsibility), funding (Commonwealth dominated) and the extent to which private insurance and private hospitals are allowed to divert the workforce away from the public sector (Commonwealth policy).

Supply also depends upon the bed supply, where Australian States have not performed badly compared with other western countries. For example, they have provided almost exactly the OECD average number of hospital beds per 1,000 population (3.6 compared with 3.8) despite a younger population; slightly more discharges per 1,000 population (162 versus 158) and a shorter length of stay (6.2 versus 7.4 days per patient) (OECD 2009).

It is possible, as implied in Commonwealth statements that the States have failed due to their inefficient management of hospitals, which would improve under the proposed DRG based case payments and, post-COAG, by means which have not been announced. But the evidence supporting these claims is scarce. Median queuing times have increased, as asserted in the publicity surrounding the intervention – from 28 in 2003-04 to 34 in 2007-08. But this has occurred in all states (except Tasmania) irrespective of the funding formula, implying if Commonwealth government accusations were correct, a coincidental deterioration in efficiency in all States but one.

DRG case payments are a good (cost based) classification of patients but have been oversold as the key to efficiency. Victoria, for example, which first introduced this system, had a Casemix adjusted cost per separation of $4,172 in 2007-09 – only 1.4 percent below the national average.
figure of $4,232. Variation in DRG adjusted costs per separation between the major States in 2007-08 is small with costs in comparable large hospitals varying from 95.6 to 104.1 percent of the national average in Queensland and WA respectively. More generally, the indicators of broad hospital performance shown in Table 1 reveal surprisingly little difference. If it were possible for every State to perform at the level of the most efficient, according to each indicator, the overall saving would only be equivalent to several months’ growth in hospital costs. In sum, the intervention cannot be justified by alleged inefficiencies as revealed by a comparison of State performance.

### Table 1. Hospital statistics 2007-08

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>WA</th>
<th>SA</th>
<th>TAS</th>
<th>AUST</th>
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</thead>
<tbody>
<tr>
<td><strong>Cost/case mix adj</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Cost/separation (index)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Large hospital (index)</td>
<td>98.6</td>
<td>95.8</td>
<td>95.6</td>
<td>104.1</td>
<td>99.6</td>
<td>Na</td>
<td>($4160)</td>
</tr>
<tr>
<td>All (index)</td>
<td>101.5</td>
<td>98.6</td>
<td>98.6</td>
<td>104.1</td>
<td>0.92</td>
<td>108.8</td>
<td>($4232)</td>
</tr>
<tr>
<td>Hospital Expenditure/person</td>
<td>1.02</td>
<td>1.03</td>
<td>89.4</td>
<td>1.07</td>
<td>0.93</td>
<td>1,264.7</td>
<td>($1360)</td>
</tr>
<tr>
<td>Relative stay index</td>
<td>1.07</td>
<td>0.91</td>
<td>0.97</td>
<td>1.00</td>
<td>1.04</td>
<td>1.01</td>
<td>100</td>
</tr>
<tr>
<td>Days queued at 50\textsuperscript{th} percentile</td>
<td>39</td>
<td>33</td>
<td>27</td>
<td>30</td>
<td>42</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>% queue within triage time</td>
<td>76</td>
<td>71</td>
<td>63</td>
<td>61</td>
<td>61</td>
<td>60</td>
<td>69</td>
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The real problem justifying the intervention can be seen from a perusal of the State financial position (see Figures 1a, b, c). In 2003-04 the balance of their financial accounts was a surplus of $33.2 billion. By 2008-09 it was a deficit of $46.5 billion. Over the same period the Commonwealth brought its financial deficit from $71 billion to a small surplus. The Commonwealth has, in effect, transferred debt to the States by its failure to pass on revenues. One symptom has been the decline in the Commonwealth share of public hospital funding from 44.6 percent in 2003-04 to 39.1 percent in 2007-08. During the same period the State commitment rose from 47 to 54 percent. Hospital separations rose by 40 percent over this period (AIHW 2008). However, without adequate Commonwealth resourcing, this response did not match surging demand. That is, Commonwealth intervention was necessary primarily because our system of taxation and financial transfers does not match the historical responsibilities of the jurisdictions and the problem has been worsening. This has been exacerbated, as noted, by the training of inadequate numbers of doctors (ultimately a Commonwealth responsibility) and the drain of the publicly funded medical graduates into the private sector as a result of Commonwealth private health insurance policy. An alternative to the Rudd proposal would have been the rebalancing of fiscal powers and responsibilities under the Federation or an agreement to transfer an equivalent increase in funds to the States without a change in governance.

The Rudd reform was preceded by neither a detailed public enquiry into the governance of the health system nor cogent arguments for any particular form of intervention. The NHHRC failed in this respect (Richardson 2009). In its interim report each of three governance options was discussed in one page and in chapter 6 of the final report even less space was devoted to the issue (National Health and Hospitals Reform Commission (NHHRC) 2009).
Figure 1(a) Commonwealth debt and deterioration in State financial balance 2003/04-2008/09

Figure 1(b) Share of hospital budget

Figure 1(c) Waiting times, all Australian public hospitals
In the longer term three broad paths are still available. First, the status quo with all its attendant problems could be retained. Secondly, the Commonwealth could progressively increase its influence and control to establish a single national monopoly. Thirdly, diversity could be achieved simultaneously with incentives and governance structures to achieve coordination by devolving Commonwealth authority and responsibility to the States, possibly building upon the newly announced Funds which are to receive the Commonwealth monies. A variant of this option would be to create regional budget holders.

Below I argue that a Commonwealth monopoly is the worst of these strategies and that diversity is to be preferred. Even the status quo has one major advantage over a single monopoly. States and the Commonwealth are both large enough to detect, and are motivated to publicise, errors committed by the other authority. Blame shifting may be politically motivated but it is also a crude method of error detection. While imperfect, it is better than error suppression.

2. Continuation of the status quo

The COAG agreement leaves serious reform of the health sector in limbo. The States will retain control over the hospitals and the Commonwealth over medical, pharmaceutical and aged care. Dental health will continue to depend largely upon parental genes and income. As noted above, problems associated with hospitals will be attributed to funding by the States and mismanagement by the Commonwealth. Governance to achieve coordination of problems and sectors, in effect, is essentially unchanged.

To evaluate the essentially unchanged health system requires a criterion. Elsewhere I have argued that the most important characteristic of a good system, qua system, is that it is adaptive; that errors will be detected and corrected and that good ideas will be identified and adopted (Richardson 2009). Using this criterion, Australia has a poor health system. Problems which have been known for decades have not received serious attention and the mechanisms for error learning are cumbersome, bureaucratic or non-existent. This situation has again been primarily the responsibility of successive Commonwealth governments and their Health Department which, before COAG, were to have assumed full control of the system.

In terms of equity, the most obvious failure has been the neglect of indigenous health. Despite the complexity of the issue, there are few who presently doubt the lethargy and disinterest which characterised past policy. Contention only surrounds the extent of present commitment.

Failure with respect to fairness – the foundation value of Medicare – is also obvious in the unequal access to services. Many requiring dental, mental or pharmaceutical services receive second class or no care. Huge geographic discrepancies in the use of medical services were documented for 1976 – the first year in which comprehensive data were available (Richardson and Deeble 1976). Despite many ‘mini initiatives’ the problem remains unresolved. One Commonwealth response to the problem appears to have been the restriction of access to embarrassing information. As documented in Richardson (2009) the present author was unable to obtain historical Medicare data, held exclusively by the Commonwealth Department of Health and Ageing, for a detailed examination of changing access through time. After six years of repeated requests, including four letters from the Monash Deputy Vice Chancellor (Research) (three unanswered) the grant for the research had to be returned to the NHMRC. As argued below, the consequences of government control of data is a pivotal issue for system reform.

New technology has been the great driver of human welfare generally and new technologies have dominated, and will continue to dominate, both the costs and the benefits of health services.
Despite this, lamentably little attention has been given to health technologies at the level of health service diffusion and delivery. The overall research effort in Australia is dispersed, uncoordinated and reactive and appears to have little error learning capacity. There is insufficient national capacity to evaluate old therapies retrospectively or to monitor outcomes. The data for this is collected and not used. There is no mechanism for ensuring that new technologies will be identified and made available to those who could benefit.

Dwarfing all other failures is the Commonwealth response to the 1995 Quality of Australian Health Care Study (QAHCS). This indicated that between 9-12,000 patients die annually through avoidable adverse events. The problem is not primarily at the level of individual doctors, who like others, make mistakes. The problem is systemic and, in particular, the systemic failure to fully incorporate error learning. Ten years after the QAHCS report an MJA Editorial noted that “...25 patients die each day from...preventable events...we still have no nationally accepted framework for clinical governance” (Van Der Weyden 2005). By 1996 the chair of the body responsible for reform noted that “regrettably, improvements are still patchy” (Baraclough and Birch 2006) and in 2009 a DHA report noted that “there is currently very little information about the quality of care provided in primary health care” (Department of Health and Ageing 2009).

The question of why these issues have been inadequately addressed is of central importance to the health system and its reform. My own explanation, which is the starting point for my system reform suggestions below, is that firstly, and of overwhelming importance, information has been deficient. Most of the public have not known about the problems. Secondly, governance of our institutions is such that there have been weak or no incentives for any individual or body to resolve the problems when information was available. Thirdly, Australian health policy has been deeply political, resulting in interest group appeasement rather than population health being the principle driving force. In sum, a continuation of the status quo, albeit with a trivial tweak to the method of dispersing funds, will result in a continuation of preventable suffering.

3. Monopoly

The second reform option, and the one initially sought by the Rudd government, is the establishment of Commonwealth control over all health services. There should be little need to document the problems arising from monopolies: it has been the subject of Economics for 250 years and most western governments, including Australia, have established legal entities to break up arrangements which lead to an excessive market concentration. Depending upon the context, monopolies may sometimes be inevitable or the best available option, but such cases need careful justification and careful regulation.

What then is the case for creating the country’s largest monopoly under the direct control of an entity – the federal government – which cannot be regulated except by elections which occur infrequently and are the result of numerous other influences apart from the health system. The case has not been made or properly discussed in the context of health care.

Centralised control has some attractions – ask any dictator. The comment is not flippant. It is easy to make mental pictures of how efficient organisations could be run if people follow ‘The Plan’ – and this thinking may underline the NHHRC report. It clearly underlies a common argument which takes the form that ‘the Commonwealth may...therefore the Commonwealth will...’, although the latter part of the argument is usually implicit. But it was the rejection of this type of thinking which liberalised western markets and permitted the explosive economic development of the past 200 years. The mindset was encapsulated by the founder of modern economics: Adam Smith, in his famous statement that:
The man of system ... seems to imagine that he can arrange the different members of a great society with as much ease as the hand arranges the different pieces upon a chess-board ... but ... in the great chess-board of human society, every single piece has a principle of motion of its own. (Smith 1759)

Allowing flexibility and freedom for people to follow that ‘principle of motion’ – or personal motivation – laid the basis for the growth of material and personal wellbeing.

Of course, some regulation and restrictions are an unavoidable part of group living and the extreme libertarian vision of universal and unregulated markets is as unrealistic as fundamentalism generally. However, recalling the then revolutionary idea of Adam Smith is a useful warning to those who play mental chess.

There are, in fact, few parts of the society where the unregulated market is less applicable than the health sector and it is for this reason that arguments can be found for concentrating power. However, the key questions, discussed below, are whether or not this means concentration with only one government and what checks and balances should be established.

The most obvious reason for a Commonwealth monopoly is that it may facilitate the achievement of equity – the same access to health services for all Australians – and avoid differences arising in different States. But not only the chessman, but also the ‘men of system’, do not always perform as envisaged. The Commonwealth government has controlled payments for medical services since 1974 and huge inequalities in the access to these services still exist. More generally, regions and population groups have different needs and preferences and a system needs the flexibility to treat people with differences differently. As outlined below, there are more powerful ways for achieving fairness than waiting for a body remote from the coalface to provide it.

The most common argument for a Commonwealth takeover at present is that the Commonwealth has greater fiscal resources and that health expenditures are likely to grow faster than State revenues. For example, in announcing partial agreement to his plan by COAG on April 20, Rudd cited projections indicating that the health budget could shortly consume all State revenue, jeopardising education, infrastructure and, indeed, the Federation itself. The argument is appealing because it is simple. Hospitals are costly and the Commonwealth has a lot of money. The argument, however, is a poor one. From a long term perspective we need, firstly, to decide upon the best system of health delivery and financing and, secondly, how to fund it. This may mean ceding tax or tax powers from the Commonwealth to the States or Regions. The reverse – shoehorning the health system to match a dysfunctional tax system – jeopardises the health of future generations as it is unlikely that having taken over power from the States the Commonwealth will return it irrespective of the consequences, which can be easily rationalised, as the alternative potentially superior outcomes will be a counterfactual.

One gaggle of arguments concerns the administrative savings from a single national scheme. The force of this argument depends more upon a conditioned dislike of words like ‘bureaucrat’ and ‘administrator’ than from evidence. No organisation can run without administration and the administrative costs of the Australian health system are about 2.7 percent of recurrent costs: 3.2 percent for the Commonwealth sector, 2.5 percent for the State sector and 11.2 percent for private health insurance (AIHW 2009). Elimination of the entire health bureaucracy – public and private – would mean, apart from an anarchic system, a saving equivalent to about 7 months growth of health expenditures. That is, administrative costs are not as important as some often implied.
The more serious arguments concern the existence of possible economies of scale, the buying power of a monopsonistic Commonwealth authority, the efficiency of the Commonwealth government and the (unmeasured) overlap which exists between levels of government. The latter is not a problem with any true clarification of governance and funding. Economies of scale certainly exist in the collection of tax revenues and the use of Medicare Australia (formerly the Health Insurance Commission) to centrally process medical and pharmaceutical claims. But these technical functions can continue under a wide range of different schemes with debits and credits electronically transferred to the budgets of multiple State or Regional based systems.

It is true that successful monopsonistic purchasing may drive down prices. However, the evidence is too weak to make this a strong argument. The medical sector is a Commonwealth responsibility but Australian private specialists’ incomes are 4.3 times higher than the average wage. This makes them the 8th most expensive doctors amongst the 21 countries reported by the OECD. In contrast, GPs have the second lowest incomes (after Hungary) with an income of 1.8 times the average wage (OECD 2009). This may be the result of Commonwealth efforts to restrain benefit payments to less powerful doctors. If this outcome was desirable (which is questionable given the shortage of GPs) then centralised control of rebates could continue in a diversified scheme. However, successful negotiations are possible with smaller monopsonistic bodies than the Commonwealth. New Zealand, for example, buys many of its drugs at two thirds the Australian price (Spinks and Richardson 2010).

In sum it is easy to build mental models in which the Commonwealth government is highly efficient in comparison with recalcitrant States. However, there is little evidence to suggest that this is true although the allegation is easily made. To the contrary, the Commonwealth has a track record of multiple failures – the health of indigenous Australians, adverse events, health workforce shortages, program integration, equity of access and the integration of Private Health Insurance into the system.

The point is not to assign blame but to highlight the inevitability of error – human and institutional fallibility – in a complex system. The key question is whether, given this, we create a politicised monopoly characterised by self interest and with incentives for information and error suppression. Economic theory and history answers this question with an emphatic ‘no’.

4. Diversity with market dynamism

The most recent comprehensive proposal for a new health system was made by Dick Scotton (Scotton 1999) who, with John Deeble was one of the architects of the original Medicare/Medibank system. Scotton subsequently concluded that Medicare had reached its ‘use by date’ and proposed an Australian version of Managed Care, the scheme which Clinton did not, but Israel, the Netherlands and a number of other European countries, did, implement.

The structure and logic of the Scotton plan shown in Figure 2 is simple and elegant. The system is primarily tax funded, as at present, but from one source, the Federal government. Each individual is assigned a dollar amount based upon their health and likely spending. This is the key to equity. The money is transferred to a public or private ‘Fund’ of the person’s choice and this organises all of the services for the individual, possibly by contracting. People who do not actively select a Fund are assigned to a geographically based public Fund. Individuals can attend any public facility as at present, but with the possibility of different copayments to encourage use of services contracted by their Fund.
The government’s role is to act as the regulator to ensure that a minimum package of services is provided and not subject to an erosion of quality. In principle, improvements are driven over time by competition: between Funds and between providers, (doctors, hospitals, etc) in an ‘internal market’ with the Funds.

The National Health and Hospitals Reform Commission (NHHRC) proposed an enquiry into ‘Medicare Select’ which is (without acknowledgment) ‘Scotton-lite’, ie the Scotton plan minus the detail and without the residual government ‘Funds’ which would, initially, dominate the market in the Scotton conception. No substantive argument is offered for the Medicare Select plan and it is doubtful if it was intended as a serious option.

However, the idea of capturing the dynamism of the market is attractive, especially when contrasted with the likely outcome of a government monopoly. In my view, however, the Scotton plan has two broad problems. First, there is an excessively large disjunction between the current system and the Scotton scheme so that its risks are too great for its adoption without a transitional stage from which we may or may not proceed after testing, trialling and preparation of infrastructure. The risks include the likelihood of ‘competition’ by marketing – cost effectiveness being replaced by ‘cost attractiveness’. This could result in the escalation of costly, marginal, or even harmful technologies. Added to the undoubted increase in administration, costs might easily outweigh the unknown benefits of competition.

Secondly, and related to this, information in the health sector is so poor, ambiguous and, at the individual level, variable in its interpretation that ‘competition’ by itself is a doubtful way of achieving improvement through time. In the market model and successful marketplace, sufficient information is conveyed by price signals but this cannot occur in the health sector.
My own suggestions, summarised in Figure 3, address these two problems (Richardson 2009).

First, Medicare should be devolved entirely to the States or to large Regions (500,000 or more) and its funding and broad regulation follow the Scotton plan (ie they would be Commonwealth responsibilities). States/Regions would provide or arrange the services and delivery model and have significant scope for experimentation and innovation.

**Figure 3 Regulated regional care**

Depoliticisation should be achieved by the establishment of statutorily independent ‘Health Authorities’ to govern the ‘Funds’. They, in turn, would be answerable to a single ‘Australian Health Board’ (AHB) which, like the Reserve Bank is statutorily independent but with a government determined Charter. Like the Reserve Bank, the AHB would have powers to regulate and, if necessary, to intervene in the operation of Health Authorities. Market competition would not, initially, occur in this market but private health funds could provide services omitted from the Health Authority’s packages.

In the longer term experimentation with ‘carve outs’ of coherent markets could be undertaken in which private Funds provided whole of care health packages in competition with public Medicare.

The second problem, the engine of progress – how to make systems improve and deliver what we want - has been largely ignored. In the absence of effective price signals, information should be provided by an ‘Australian Institute of Health Service Performance and Research’ (AIHSPR), a statutorily independent authority similar to the Australian Institute of Health and Welfare but with a different Charter. Its role would be to seek and circulate all forms of relevant information and the results of system and research. This would include the Health Authority’s success with respect to stated objectives, research into system performance, evidence of new technologies and successful ideas introduced overseas.
The data would be provided proactively, in an appropriately targeted form, to the public, the Health Authorities, health care providers, media commentators and, importantly, the Australian Health Board which, under defined circumstances, would intervene to require change.

Public dissatisfaction would be registered and reported by the Health Authorities, the AIHSPR and the AHB. Members of the AHB, the penultimate authority could be appointed like High Court judges or members of the Board of the Reserve Bank. The Federal government, the ultimate authority, could change their Charter but this would be by Act of Parliament, requiring debate and public discussion.

My own schematic representation of this system (Figure 3) is similar to Scotton’s schema (Figure 2). But it differs in one key respect, rather than tracing the flows of money, it emphasises governance and information. In the supply-demand schema of a competitive market, price takes central stage reflecting its pivotal role conveying information. In Figure 3 the AIHSPR takes the central position for the same reason.

5. Conclusion

The Australian health care system is long overdue for a truly comprehensive examination of its governance. The reason why this has not occurred is political. Andrew Podger reports that in his capacity as Secretary to the Health Minister he would suggest a major review of the health system ‘almost every other year’. (The Minister) would respond that articulating clearly the long term direction was as dangerous as ‘big bang’ reform (Podger 2006).

More generally, the quotation illustrates one of the greatest problems facing the reform in Australia, namely the politicisation of decision making and its consequences. Dynamic efficiency – seeking out and adaptation in the face of new information – is severely inhibited when inevitable errors are distorted and exploited for political reasons and error suppression and spin replace informed debate and experimentation.

The best that can be hoped for from the present intervention is that it will establish a holding pattern while a more thoughtful, evidence based enquiry into system governance is undertaken.
References


