Government Senators' Dissenting Report

1.1 The Coalition members of the Senate Select Committee on Health consider that the 'majority interim inquiry report ("the Report") fails to acknowledge the complex issues regarding the provision of healthcare. This failure is a result of a lack of focus and purpose in the Committee and partisan conduct in the pursuit of its agenda.

Structure of the Committee

1.2 It is the Coalition's view that the Select Committee on Health suffers from the following shortcomings:

- management of Health delivery is an outcome under State jurisdiction. The Terms of Reference do not take into account State management and how the Committee proposes to influence the States regarding outcomes;
- the Terms of Reference also do not mention how the Committee proposes to influence COAG and what outcomes it would take to this process;
- indistinct terms of reference;
- a lack of foreseeable actionable outcomes;
- a scope and scale that duplicates much of the work of the Community Affairs Legislation and Reference Committees;
- an agenda that appears unduly partisan;
- a considerable cost to the tax payer which, in the context of the aforementioned observations, we consider to be unjustifiable; and
- the Terms of Reference are well beyond the Health Department's remit.

Hearing dates and cost

Hearings

1.3 The Committee emphasised that they wished to focus on hearings in regional areas. Of the 13 regional hearings proposed by the Chair –

- 5 have since been cancelled;
- 4 that were scheduled to be full days, were only half days (due to lack of witnesses); and
- 1 has been postponed.

1.4 Therefore despite the Committee's purported focus on regional areas, there is yet to be a full day hearing in a town outside the capital cities.

1.5 The Committee has held 10 hearings in capital cities, including 5 in Canberra. Of the hearings in Canberra, 4 hearings were focussed on witnesses that appeared

before the Community Affairs Committee at Supplementary Estimates in October.[1] Hearings in Canberra also had to be cancelled at the last minute due to lack of witnesses (non-government bodies), or were late to start due to lack of quorum (despite being in Parliament House on a sitting day).

1.6 As the Committee can reach quorum with only Labor and Greens' members present, 10 hearings have been held without Coalition Senators. No Senators outside of Labor, Greens or the Coalition have attended a hearing.

Health expenditure

1.7 There is currently unprecedented pressure on the federal budget due to the $123 billion in future deficits left by the former Labor Government. Without policy changes, this debt will reach $667 billion.[2]

1.8 The Commission of Audit has stated that health care spending is the Commonwealth's single largest long term budget challenge.[3] Ten years ago the Australian Government spent $8 billion on Medicare; in 2014-15 the Australian Government will spend $19 billion. In 10 years' time this expenditure is projected to be more than $34 billion.[4]

1.9 The Department of Health submitted that in 2011, Australia's annual real rate of growth of total health expenditure was 4.2 per cent. It stated that this was higher than the average across the OECD, at 3.9 per cent. This placed Australia in the 2nd highest quintile on this measure.[5]

1.10 The Report fails to acknowledge the current pressure on the federal budget or provide any alternative means of maintaining sustainable growth in health expenditure. The report also fails to note that while the Government is seeking to bring health expenditure under control, spending in health is still budgeted to rise substantially in coming years.

$7 co-payment

1.11 The taxpayer currently funds 263 million free services a year under Medicare. Ten years ago the Government was spending $8 billion on the MBS, today it's $19 billion, and in 10 years' time it will be more than $34 billion. Clearly this is unsustainable.

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1 The committee hearing in Melbourne on 8 October 2014 included witnesses from the federal departments of Health, Treasury, Finance and Human Services; all witness who appeared during Supplementary Estimates hearings in October 2014.

2 Commonwealth of Australia, Budget Paper 1, p. 1-1.

3 National Commission of Audit, *Towards responsible government: The report of the National Commission of Audit*, Phase One, pp 99–100; 111–112.

4 Senator the Hon Fiona Nash, Senate Community Affairs Legislation Committee, Budget Estimates, *Committee Hansard*, 2 June 2014, p. 64.

5 Department of Health, *Submission 101*, Senate Community Affairs References Committee, Out-of-Pocket Expenses Inquiry, p. 25.

1.12 Medicare is under unprecedented cost and demand pressures from an ageing population, increased lifestyle-related chronic disease, advances in technology and patterns of use.

1.13 New lower thresholds in the single Medicare safety net will help more people and ensure that safety net benefits are available to people who have serious medical conditions or have prolonged healthcare needs.

1.14 Under current rules doctors are paid an incentive fee to bulk-bill (or charge no more than the Medicare rebate) for a GP consultation to concession card holders, or children under 16. A higher bulk-billing incentive is paid to the doctor if the service is provided in a rural or remote location of $9.10 for each consultation.[6]

1.15 Under the Government's budget changes, these incentives will still apply if doctors limit their co-payment charge to $7, and will be renamed the low-gap incentive payment.

1.16 Currently there are multiple Medicare safety nets for out-of-hospital services. From 1 January 2016 a new Medicare safety net will simplify existing safety nets for out-of-hospital services whilst continuing to protect vulnerable patients. The new Medicare safety net will have lower thresholds for most people. This may allow some people to qualify for safety net benefits earlier than under current arrangements.[7]

1.17 In addition to the MBS safety net, concession card holders and children under 16 will only be required to pay the $7 co-payment, for the first 10 bulk-billed services in any calendar year for either General Practice, out-of-hospital pathology, and out of hospital diagnostic imaging. After this cap has been reached an incentive will be paid to the practitioner to bulk-bill (or charge no more than the Medicare rebate) for future services.[8]

1.18 The Government also provides a safety net limit on the out-of-pocket costs of those at risk of excessive medicine costs. Once a patient hits the PBS Safety Net threshold, they have the cost of their PBS medicines reduced. This is an important principle that has been supported by Governments of both political persuasion over many years. It is an important principle that the Government is seeking to apply consistently to Medicare to ensure it also remains sustainable into the future.

1.19 At present there are 7.6 million Concessional PBS patients in Australia.[9] In 2012-13 one in five PBS-subsidised prescriptions dispensed through community

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6 Department of Health, *Strengthening Medicare*, www.health.gov.au/internet/budget/publishing.nsf/content/budget2014-factsheet-strengthening-medicare, accessed 21 August 2014.

7 Department of Health, Budget 2014-15 http://budget.gov.au/2014-15/content/glossy/health/download/Health.pdf, accessed 21 August 2014.

8 Department of Health, *Strengthening Medicare*, www.health.gov.au/internet/budget/publishing.nsf/content/758402BC42DF82DBCA257CEE0020D480/$File/strengthening-medicare.pdf, accessed 21 August 2014.

9 Department of Health, *Submission 12*, Senate Community Affairs Legislation Committee, Inquiry into the National Health Amendment (Pharmaceutical Benefits) Bill 2014, p. 5.

pharmacies were supplied free of charge to concessional patients who had reached the safety net.[10]

1.20 Safety net arrangements will continue to protect very high users of medicines under the Government's proposed budget changes.

Merger of the Organ and Tissue Authority and the National Blood Authority

1.21 The Report also recommends that the Government cease its planned merger of the OTA and NBA. Coalition Senators reject this recommendation as it contradicts the evidence given by the NBA during Committee hearings:

> No. If anything, we see the merger as offering opportunities and certainly, in terms of getting staff buy-in, most staff are looking forward to it and do see it is an opportunity…**Some of those efficiencies are already being realised.** [Emphasis added.][11]

1.22 And from the OTA on 4 September:

> The amalgamation of the National Blood Authority and the Organ and Tissue Authority is predicated on there being continued emphasis and focus on delivery of our program objectives, targets and strategies. The merger, as you would know, entails a commitment from the government to continue the critical clinical supply programs of a national safe blood supply and continued growth in organ and tissue donation, and it is **principally focused on streamlining the Australian Public Service on working out where there can be more efficient use of our administrative arrangements and reduction in duplication.** [Emphasis added.] So we are working carefully and methodically to make sure that those objectives can be achieved and that the merger can take place from 1 July 2015. But our overriding goal in that is to make sure that there is continued delivery of our program objectives and that it is not impacted.[12]

1.23 This merger forms part of the Government's overall strategy to reduce inefficiencies, cut red tape, and build a more productive economy.

Medicare Locals

1.24 Coalition Senators reaffirm the independence and thoroughness of the review of Medicare Locals undertaken by Professor John Horvarth AO, former Chief Medical Office of Australia. Lack of clarity in what many Medicare Locals are trying to achieve, with considerable variability in both the scope and delivery of activities has resulted in inconsistent outcomes, dispirited stakeholder engagement, poor network cohesion, and reduced sector influence.

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10 Department of Health, *Submission 12*, Senate Community Affairs Legislation Committee, Inquiry into the National Health Amendment (Pharmaceutical Benefits) Bill 2014, p. 11.

11 Mr Leigh McJames, Chief Executive Officer, National Blood Authority, *Committee Hansard*, 25 September 2014, pp. 2-3.

12 Ms Yael Cass, Chief Executive Officer, Organ and Tissue Authority, *Committee Hansard*, 4 September 2014, p. 2.

1.25 The Government has accepted the recommendations of the review and will establish Primary Health Networks. Coalition Senators support the Government's focus during this transition period on frontline services.

Recommendations

1.26 The Report focusses on changes to co-payments for health expenditure and fails to address the context and reasons for the changes and the fiscal challenges inherited by the Government. The recommendations provided in the Report focus on a series of reviews that would further delay necessary reforms to health expenditure and further increase the unsustainable burden that growing health costs are having on the federal budget.

Recommendation 1

1.27 That Coalition members of the Committee recommend that the Senate support reforms to improve the sustainability of health expenditure as provided for in the 2014-15 Budget.

Senator Sean Edwards

Liberal Senator for South Australia

Senator Zed Seselja

Liberal Senator for Australian Capital Territory

Senator John Williams

Nationals Senator for New South Wales