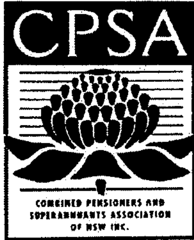


COMBINED PENSIONERS AND SUPERANNUANTS ASSOCIATION OF NEW SOUTH WALES INC.

Founded 1931.
Serving pensioners of all ages, superannuants and low-income retirees.

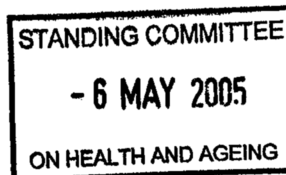
Consumer Protection Awards – 2002, 2003, 2004

SUBMISSION

6 May 2005

Our Ref: ASC.020
GFH.002

Inquiry into Health Funding



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Introduction

Combined Pensioners and Superannuants Association of NSW Inc (CPSA) is a non-profit, non-party political membership based organisation serving the interests of pensioners of all ages, superannuants and low-income retirees. It has around 145 branches and affiliates with a combined membership of over 12,500 throughout NSW. CPSA also serves the interests of its membership and broader constituency at the local, state and federal levels.

CPSA's members and wider constituency include older people, sole parents, people with disabilities and their carers. For various reasons, they have a great interest in how Australia's health system is funded. One salient reason is that they find themselves in the situation of needing to access health services. Whether it is to take a sick child to the doctor, an urgent need for a new wheelchair, accessing dementia services for an ageing relative or simply getting a script for medication, the people we serve need to know that an efficient, well funded health system will be there for them. A system that is starved of funds or cannot use funds because of structural limitations is of no benefit to anyone in the community and certainly not in the interests of those who most frequently require the services of that system.

With the above perspective in mind, this submission will address the various points within the committee's terms of reference.

Examining the roles and responsibilities of the different levels of government (including local government) for health and related services

At present, the Federal, state and local governments all have a part to play in the funding and delivery of health services. Their roles and responsibilities overlap and have historically created confusion and conflict at various times. As Professor John Deeble from the ANU points out in regard to the Australian Health Care Agreements (AHCAs):

"The parties' obligations are thus quite different. On the Commonwealth side it is to pay money, on the State and Territory side to deliver services to acceptable standards, whatever the cost. It is an arrangement guaranteed to create discord and blame-shifting. The States can reject the offer and need not spend the money but they are so locked in by public expectations and political forces that it is not a realistic long-run option. The financial

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details have therefore never deviated far from the Commonwealth's first offer. Indeed, the legislation provides that even if a State or Territory does not accept it, the Commonwealth offer will stand. It was well into the term of the 1998 agreements before Western Australia finally signed" (Deeble, 2002).

In addition, local government also has a part to play in health funding and service delivery. A survey conducted by the Shires Association of NSW found that respondent councils:

"...are spending around $2.2 million per year providing the types of medical and related health services that are arguably the role of central governments to provide" (Baum, 2004).

The same report states that nearly half a million per annum is given by councils to subsidise medical and related health services.

And, of course, it is not only government that provides services. The NGO community sector is also funded to deliver a range of health services by different levels of government.

There is continuous debate around the roles and responsibilities each part of government should take in regard to the health system. Recently, there has been an argument about whether the states should retain control over the hospital system or whether they should be taken over by the Commonwealth. In 7 April 2005 *The Sydney Morning Herald*, the Minister for Health and Ageing, The Hon Tony Abbott MP, stated:

"The Federal Government is prepared to continue its commitments under the health care agreements, but we have no plans to take on any of the states' responsibilities in running hospitals" (Dodson and Davies, 2005).

This is good news from CPSA's point of view. As Premier Bob Carr suggested in the same article, a new bureaucracy would need to be introduced in order to implement this new hospital system. Furthermore, shifting hospitals from state to Commonwealth jurisdiction would involve considerable costs in itself. This is invariably the case in any administrative restructure – especially one on that scale.

Inevitably in a federal system there will be a dispersion of responsibilities. Australia's constitutional arrangements, when they were established in the early 20th Century, were aimed at ensuring a dispersion of powers so that

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one level of government cannot get too powerful. This should be accepted rather than engaging in an exercise in cost shifting, funding leakage and centralisation.

Simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals

Funding arrangements of Australia's health care system are via the Australian Health Care Agreement (AHCA). The latest such agreement between the Australian and the NSW Governments was signed 30 August 2003 and will expire 30 June 2008. According to the Agreement:

"The primary objective of this Agreement is to secure access for the community to public hospital services based on the following principles:
(a) Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals;
(b) Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and
(c) Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location" (ACHA, 2003).

However, an information bulletin from NSW Health lists some points relating to the Agreement which are worrying:

"The 2003-08 Agreement:
- has financial penalty clauses that can be imposed if New South Wales fails over consecutive years to meet one or more of the compliance requirements;
- does not contain explicit protection for states and territories in the event of dispute or disagreement relating to funding under the Agreement" (NSW Health, 2005).

Financial penalty clauses would inevitably have a deleterious effect on the welfare of the health consumers of NSW. The *Report of the NSW Health Survey Program (2003)* indicates that an estimated 39,800 men and 42,000 women aged 75 years or over were admitted to hospital in that period. A further 48,500 men and 36,200 women aged between 65 and 74 years were also admitted. If you include people of all ages on the Disability

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Support Pension and sole parents and their children, the constituents served by CPSA make up a considerable proportion of NSW patients. Financial penalties could potentially have a negative impact on the health and well being on a group of people whose health is often precarious.

No doubt it is the intention of the Commonwealth to see that funds provided to the states under the AHCA is spent appropriately. However, "punishing" the states because of perceived inappropriate use of funding is likely to result in poor health outcomes.

In terms of the details of funding arrangements, CPSA's policy document makes this general point:

"CPSA notes that public hospitals are chronically under-funded and there are too few nursing home beds. CPSA demands a new Commonwealth-State funding system for the Australian public hospital/nursing home system" (CPSA, 2003).

The document also clearly states opposition to cuts to the financing of public hospitals and privatisation of health services. This is because CPSA's members and broader constituency are likely to be on the receiving end of poor funding arrangements.

However, it seems that funding alone may not go anywhere near solving the problems affecting health financing:

"More money will no doubt help the pressure being felt in public hospitals. There are, however, underlying problems that, though not helped by budget cuts, will not be solved by money alone. These include shortages of nursing and medical staff and safety and quality issues. In all of this, transferring responsibilities for hospital funding from Commonwealth to States, or States to Commonwealth is only a distraction" (Hall, 2004).

A media release from the Australian Institute of Health and Welfare (AIHW) in September last year indicated that:

"The Australian Government's share of public hospital funding was $8.6 billion (49.2%) [2002-03], compared to $8.0 billion (49.2%) in 2001-02. The state, territory and local government share was $7.5 billion (42.9%), compared to $6.9 billion (42.3%) previously" (AIHW, 2004).

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In other words, we have seen real growth in health funding but the system is still fraught with problems. And that is not all. The AIHW also makes the point that:

"Spending on health by Australians from their own pockets was up by 5.6% in real terms compared to the previous year. This spending growth has averaged 8.3% per year between 1997-98 and 2002-03, 3.2% above real annual growth in health expenditure overall over this period" (Ibid, 2004).

Australians are spending more of their own money while at the same time more of their tax money is being outlaid on health. This is a worrying trend, especially for those who can least afford it, and points to the need to overhaul the health financing system so the money is better targeted towards positive health outcomes. In this regard, CPSA supports the establishment of a single, independent, bipartisan, national agency, with an assured needs-based budget, to assume control of the Australia-wide health system.

Considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved

Accountability to the Australian taxpayer for quality health services should be considered a given. However, accountability requires a commitment to public health. If the commitment is lacking then accountability is simply an empty statement.

As Deeble has demonstrated, the negotiation around AHCAs involves too much political gamesmanship. This is at the expense of better health service provision and outcomes. As John P Paterson said in *The Medical Journal of Australia* in 2002:

"In their joint statement of 5 April this year, the Federal and State Health Ministers acknowledged a widely recognised but rarely voiced truth – that past negotiations under the Australian Health Care Agreements (AHCAs) had focused more on health funding than health outcomes. The Ministers' candour took many completely by surprise" (Paterson, 2002).

In other words, those in charge of health funding know that the good health of the Australian community is paramount and takes precedence over funding arrangements. And yet there seems to be too much political buck passing when it comes to drawing up AHCAs.

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Paterson goes on to suggest a sound proposal to improve quality and accountability in regard to health service delivery:

"If Ministers wish to entrench quality, safety and patient choice as the primary drivers of care, they must take measures to move the locus of control away from the input end of the production chain and toward the output end – that is, toward the consumer. This does not imply dismantling equitable and universal health insurance. It simply means that government must move towards a health financing system that insures the patient" (Ibid, 2002).

It also should be emphasised that ideological commitments to private health provision needs to be jettisoned if the Commonwealth and the states really are serious about quality and delivery of public hospitals and medical services. As Peter Davoren of the Doctors Reform Society (DRS) says:

"...much of the work of our public hospitals goes into looking after the chronically ill. Chronic heart and lung disease, cancer, stroke and diabetes are the big killers in Australia and caring for people with such illnesses consumes vast resources. It is well recognised that those people with chronic illnesses are more likely to be elderly and/or of low income compared with the general population, and people with limited income are more likely to suffer ill health" (Davoren, 2001).

It is this group of people who are unlikely to afford private health insurance or be able to make use of private hospital services. And at any rate, private hospitals are more limited than public hospitals in terms of facilities and services. Clearly, the Australian public (especially those with illnesses and conditions that require acute care) need a viable quality public hospital system. It is this system that must receive the lion's share of commitment and resources.

How best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government

It needs to be asked why a strong private health sector needs to be sustained into the future. It could be argued that the private health sector is more efficient than its public counterpart. This is questionable. As Duckett and Jackson argue in regard to the private health insurance rebate:

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"The subsidy cannot be justified on efficiency grounds, as, on the basis of available evidence and taking casemix into account, public hospitals are more efficient than private hospitals" (Duckett and Jackson, 2000).

A Medicare fact sheet published by the DRS demonstrates the efficiency of public health as a whole:

"The Health Insurance Commission's administrative costs are low. There's no advertising and no premiums to collect. Bulk billing substantially reduces the costs of processing claims compared with the costs of processing individual patient claims. Service patterns for practitioners and patients can be easily monitored to detect fraud, over-servicing or inappropriate patterns of services.

"Universal access to public hospitals without charges or means testing reduces hospital administration costs. The budget caps that apply to public hospital funding are said to encourage efficiency. Such funding constraints do not apply as strongly to funding of private medical services or private hospitals. Governments are also able to impose other funding arrangements in public hospitals which encourage efficiencies, for example, casemix arrangements. Doing this is much more difficult in the private sector" (DRS, 2001).

If it is the case that the public health sector is more efficient than its private counterpart as the DRS explains then what role should the private sector have in Australia's health system? First of all, the roles of the different parts of the private sector need to be looked at.

Medical practitioners and specialists, unless they are employed by the public health system, work privately. This arrangement would work well for consumers except that practitioners do not receive adequate remuneration from the Australian Government to encourage them to bulk bill. This is partly why some areas of Australia have seen catastrophic falls in bulk billing rates. For instance:

"[Dunkley, Flinders, Ballarat, Isaacs, Latrobe, Goldstein, Casey, Holt and Corangamite] electorates [in Victoria] have experienced a marked decline in bulk billing, ranging from a reduction of 31% in Dunkley in Metropolitan Melbourne, to a reduction of 23% in Ballarat in regional Victoria" (Griggs and Atkins, 2004).

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If the Medicare Levy was raised by even one percentage point there would be considerably more funding to entice doctors back into the bulk billing system by ameliorating their expenses and provide them with adequate earnings. It could also be used to fund dental health care.

The private hospital sector has an ancillary role in Australia's health system. In their most recent annual report, the Australian Private Hospitals Association cited figures from the AIHW indicating that they treat 4 out of 10 patients admitted to hospital (APHA, 2003/04). However, using AIHW figures, the same report also shows that the majority of surgery (56 per cent) in Australia is carried out in private hospitals (Ibid, 2003/04). But these figures need to be looked at closely. Private hospitals don't carry out the majority of all forms of surgery. For instance, only 42 per cent of coronary bypass surgery is performed in private hospitals (Ibid, 2003/04).

It also needs to be asked how many low income earning patients such as pensioners and superannuants are treated in private hospitals. And how many people would use private hospitals if private health insurance subsidies were not available? These issues need to be addressed in order to see whether there is justification to sustain the private health sector in the future. There does seem to be some justification. After all, Medicare effectively funds private medical practitioners. But to fund the private sector on ideological grounds or supposedly to achieve "balance" may not be the best use of taxpayers' money nor the best way to ensure optimum health outcomes.

In this regard, the private health insurance industry, the other major player in the private health sector, will be examined separately.

While accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover

The Australian Government justifies subsidies to the private health insurance industry via the Private Health Insurance Rebate in terms of necessary funding in order to restore the balance to our health system (http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-privatehealth-rebate-consumers-rebate.htm).

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Despite the confident assertion that "All Australians will benefit from the Federal Government 30% Rebate on private health insurance" (Ibid, 2005) this appears not to be the case. And it is not cheap:

"The 30 per cent rebate substantially reduces the cost of private health insurance for those who decide to have it but the cost of this policy to taxpayers is estimated to be in excess of $2.5 billion per year" (Denniss, 2005).

Nor has it stemmed the rise in premiums:

"Over the past five years private health insurance premiums have risen 23 per cent. From [September 2004], those with private health insurance face an average increase of 7.6%, or three times the consumer price index. This rise in the cost of private health insurance means a greater burden on taxpayers because of the open ended 30% private health insurance rebate on the price of private health insurance, currently valued at around $2.5 billion per annum" (Macfie, 2004).

Many holders of private health insurance can absorb these rises in premiums – even if they do strain the national health budget. But who are holders of private health insurance? Research cited by Macfie indicates only 19 per cent of those earning less than $20,000 per annum and 27 per cent of those earning between $20,000 and $29,999 hold private health insurance. By contrast, 73 per cent of those on over $130,000 a year have private health cover (Ibid, 2004). And who is likely to be hospitalised in regard to income earnings?

"The very people who rely most on our public hospitals are those least likely to be able to afford private health insurance. In addition, even if they could, they can't afford the significant gap fees that come with private health care" (Op Cit, 2001).

A more startling illustration of the inadequacy and wastefulness of private health insurance can be seen in the US (Skidmore, 2003). In Australia, we have not gone down that road – yet. However, there are worrying trends in regard to who reaps the most benefits from Australia's health care system and what it will do to the economy:

"The Federal Government's reliance on private health insurance as a tool of public policy is delivering a disproportionate benefit to high-income earners and those who reside in high-income households. And as private

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health insurance premiums continue to rise, so too will the cost to the Federal Government of the open-ended 30 per cent private health insurance rebate" (Op Cit, 2005).

It is simply fatuous moralism to refer to particular groups of people "who can afford to take some responsibility for their own health cover". The reality is people don't freely choose health problems. Moreover, Medicare, as a universal health system, can be extended to cover health conditions it doesn't already cover. This can be done by diverting subsidies to the private health insurance industry into public health and increasing the Medicare levy. The alternative is to continue down the road of subsidising the wealthy and privileged.

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Recommendations to the Inquiry into Health Funding

1. The public hospital system should not be Commonwealth.

2. Establishment of a single, independent, bipartisan, national agency, with an assured needs-based budget, to assume control of the Australia-wide health system.

3. Hospital funding must always be carried out on a needs basis with particular attention to the chronically ill and low income earners.

4. Bearing in mind the chronically ill and people on low incomes mainly use the public hospital system; government funding must be directed to the public system as a priority.

5. Subsidies towards private health insurance should be directed towards the public health system.

6. The Medicare levy should be increased and used fund dental health care.

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