CATHOLIC HEALTH AUSTRALIA

HOUSE OF REPRESENTATIVES

Standing Committee on Health and Ageing

INQUIRY INTO HEALTH FUNDING

CHA Submission

MAY 2005

Inquiry into Health Funding

Contents

About Catholic Health Australia.. 5
Summary of Recommendations.. 7
Term of Reference 1.. 9
Term of Reference 2.. 14
Term of Reference 3.. 17
Term of Reference 4.. 20
Term of Reference 5.. 23
CHA Foundational Principles.. 36

Executive Summary

CHA believes that public funding should be provided to support a health system that provides a comprehensive level of care to the Australian community at a time of clinical need regardless of financial capacity to pay. Our comments to the inquiry will be based on this principle in addition to CHA Foundation Principles [Attachment A] to this submission.
By international standards, Australia's universal health care system provides Australians with a generally high level of health care when they need it without being denied access due to lack of financial means. The significant role played by the private sector in both the provision and financing of health services provides additional choices and innovation.

There are however, cracks in the system which leads to some Australians not being as able as other Australians to gain timely access to the care they need. The groups less well served by our health system include indigenous Australians, those with mental health illness, those with non-life threatening "elective" conditions, those in rural and remote Australia, those in some outer-metropolitan and regional locations seeking access to GP services and on occasion those seeking access to a public hospital emergency department.

CHA considers that a significant cause of the weaknesses in Australia's health care system result from the fragmented and at times dysfunctional and costly division of responsibilities for funding between the Commonwealth and the States/Territories.

With no single tier of government being accountable for the overall performance of the system, it has been too tempting for each tier to minimise its own expenditure responsibilities by attempting to move them to the other tier -- with patients caught in the middle. The constant battle between jurisdictions will only come to an end if one tier alone becomes accountable to the Australian population for financing health care.

CHA considers the Commonwealth should take this responsibility.

Having responsibility for financing the health care system does not mean the Commonwealth would run services -- in our view services are best run by the organisation that can provide the most efficient, highest quality and cost-effective services whether they are public sector (in either tier of government) or the private sector.

CHA contends that the sustainability of Medicare is best pursued by less emphasis on the ownership of the means of production and a more concerted effort to utilize the benefits of the Medicare entitlement by embracing private capital investment and capacity.

One of the major areas of dysfunction in the Australian health care system relates to the responsibility for funding care for the elderly. With the Commonwealth having responsibility for residential aged care funding and the States/Territories responsibility for public hospitals, elderly people are often caught in the middle whether being trapped in public hospitals for longer than they need because of a lack of suitable sub-acute care or by having to join lengthy waiting lists for necessary care. CHA proposes its Medicare

Seniors Plus scheme as a way of cutting through the maze. Under Medicare Seniors Plus, Australians over 75 years of age (and indigenous people over 55) would be eligible to receive access to private health care paid for by the Commonwealth. This would provide this age group with timely access to care; as a secondary benefit, Medicare Seniors Plus would reduce health insurance premiums for other private health insurance members.

With nearly 10% of Australia's GDP devoted to health care and just over 25% of this amount going to fund public hospitals, CHA considers that standards and timelines of accountability for this expenditure need to be tightened. CHA proposes that State/Territory Governments be required to provide timely, consistently formatted reports on key public hospital performance measures within three months of the end of each quarter.

One of the features that distinguishes health care from other goods and services is that consumers suffer a considerable disadvantage in terms of knowledge and access to information about their treatment options and the relative performance of providers (doctors and hospitals) in delivering that treatment. CHA strongly supports the rights of consumers to be able to make informed choices about their treatment and choice of provider.

We therefore propose that Health Ministers establish a task force to work with providers in developing a system of report cards that can be used to provide consumers with the tools they need to make informed decisions about their care. The development of report cards will need to have regard to the complexities involved in appropriately comparing the services offered by different providers to ensure that the report cards are not misleading and do not lead to unintended consequences such as the denial of treatment to the sickest patients.

In relation to the private sector, CHA supports the measures that the government currently has in place to encourage over 40% of the Australian population to take additional responsibility for their health care needs by purchasing private health insurance. Health care is expensive and the increasing costs of providing high quality care has been impacting on private health insurance premiums in recent years. These continuing premium increases are slowly having an impact on the privately insured risk profile with the average age of the private health insured population gradually increasing as some younger members drop out whilst older members continue to join.

CHA considers that any decline in the membership levels or risk profile of the privately insured population needs to be nipped in the bud and proposes a number of measures to at least sustain and possibly improve the risk profile of the privately insured population by encouraging more young and healthy people to maintain or take out private health insurance cover thus keeping premiums affordable. These measures include: increasing the tax penalty for higher income earners who do not have private health insurance to 2 percent of taxable income; increasing the lifetime health cover loading of 2 percent for each year of age over 30 to 3 percent; and exploring the possibility that private health insurance hospital policies could cover a number of services provided in an out of hospital setting provided that an appropriate additional funding source can be identified.

CHA notes that according to the Australian Institute of Health and Welfare, "Australians

living outside major cities have shorter life expectancy, higher death rates, and are more likely to have a disability compared to city dwellers". Rural Australians also have less access to the private sector than do their city counterparts. Private hospitals in rural areas face higher costs, lower volumes of patients (with a wide range of medical conditions), difficulties in attracting qualified health workers and inappropriate funding structures. The Federal Government needs to increase support for private hospitals in rural and regional Australia in recognition of their higher costs and to improve the value of private health insurance cover for rural Australians.

CHA strongly supports a continuation of the universal health insurance system, Medicare. The universal nature of Medicare enables it to achieve both equity and efficiency goals that would be weakened by a loss of universality. The enrolment of the entire Australian population in Medicare allows the attainment of economies of scale – particularly in relation to administration and the provision of some areas of high technology medicine. Any reduction in the population covered by Medicare could lead to increased fragmentation and duplication of services.

From an equity perspective, CHA would be very concerned to avoid the creation of a two-tiered system where the well-off can afford to purchase high quality health care and the less well-off are forced to use an impoverished public system. The universality of Medicare means that the most articulate and powerful in society have a vested interest in ensuring that the level and quality of service provision in the public system does not decline. Any reduction in the universality of Medicare will necessarily see some people fall through the cracks and end up without coverage at a time when they most need it.

CHA supports the continuation of the ability for people to choose to purchase access to choice of provider – whether through health insurance or directly – but only on the basis that the universal coverage provided by Medicare is not eroded.

About Catholic Health Australia

Catholic Health Australia (CHA) is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities, and related organisations and services.

Through its encompassing ministries, the Catholic health, community and aged care sector touches the lives and encounters the hopes, aspirations, struggles and difficulties of many Australians on a daily basis. The Catholic health ministry is broad, encompassing many aspects of human services. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans' health, primary care, acute care, non acute care, step down transitional, rehabilitation, diagnostics, pathology, preventative public health, and medical and bioethics research institutes.

The sector takes seriously its responsibility to be a voice for the disadvantaged as well as an advocate for a just, equitable, compassionate, excellent, secure health system that is person-centred in its delivery of care. The sector continually espouses to government and the Australian community, the value of health care as an essential social good, not merely a commodity that is used to maximise return on investment to meet the economic interests of private shareholders.

The Catholic sector includes:

65 hospitals:

- 46 private hospitals and 19 public hospitals
- approx 6,000 hospital beds in the private sector (representing 25% of the private hospital sector)
- approx 2,500 hospital beds in the public sector (representing 5% of the public hospital sector)
- 7 teaching hospitals
- 8 dedicated hospices and palliative care services.

Approximately 485 Approved Aged Care Services:

- 18,100 residential aged care beds (11.6% of the total residential aged care sector)
- 4,788 Community Aged Care Packages and thousands of people assisted through the Home and Community Care (HACC) Program and other community care support (17% of the community care sector)

- the Catholic sector is the largest church based sector in Australian aged care delivery across both residential aged care and community care.

Catholic hospitals and aged care facilities are located in each Australian State and in the ACT.

Summary of Recommendations

A.1 That the Commonwealth should assume financial responsibility for all publicly sourced health funding (but not for the ownership of public hospitals, or the delivery of public hospital services)

A.2 That regulatory arrangements governing health care provision should be examined by a Commonwealth and State/Territory taskforce with a view to creating greater alignment with funding responsibilities

B.1 That the Commonwealth should take responsibility for funding the health care needs of elderly Australians aged over 75 through the implementation of Medicare Seniors Plus

B.2 That the concept of direct funding by the Commonwealth of public hospitals be explored through a pilot arrangement with a Catholic public hospital with the involvement of the relevant State/Territory

C.1 That the Commonwealth publish annually a State of the Public Hospitals report

C.2 That the Commonwealth through the AIHW publish quarterly updates of activity in public hospitals within 3 months of the end of each quarter.

C.3 That Health Ministers establish a task force to work with health care providers in developing a system of report cards that can be used to provide consumers with the tools they need to make informed decisions about their care

D.1 That the Commonwealth establish and convene twice yearly meetings of representatives of private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government to be known as the *Australian Private Health Council* to consider issues of importance to the private health industry

D.2 That private hospitals and private health insurers establish a mechanism to address the issues of quality, payment models, data collection and analysis and electronic business processes within the private health sector

D.3 That the Commonwealth re-establish and fund the Private Health Industry Quality and Safety Committee (PHIQS)

D.4 That the Commonwealth reinstitute funding to enable the continuation of the National Health Cost Data Collection for the private sector

E.1 That the Commonwealth increase the surcharge on higher income earners who do not have private health insurance to 2%

E.2 That the Commonwealth increase the Lifetime Health Cover loading to 3% per year over 30

E.3 That, whilst maintaining the 30% subsidy for consumers to increase the affordability of private health insurance, the Commonwealth de-regulate health insurance premiums

E.4 Health funds should be required to pay private hospitals a benchmark for the cost of private hospital services (excluding prostheses and in-hospital medical services) of at least 50% of all benefits paid.

E.5 That Fringe Benefits Tax continue to apply to payment of private health insurance premiums

E.6 That the Commonwealth and private health industry examine ways to improve the value of private health insurance membership in rural and remote areas

E.7 That Medicare is retained as a universal system with no opt-out option available for private health insurance members

Term of Reference 1

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

CHA has long been concerned that the delivery of health services in Australia has fallen victim to the division of responsibilities between different tiers of Government. The costs of providing quality health care that meets the increasing expectations of Australians is rising at a much faster rate than the willingness of taxpayers through their political representatives to pay for it. In such an environment, it is of little surprise that each level of government would try to minimise the scope of their own funding responsibilities for aspects of the health care system - particularly if there is a strong likelihood that the public may be persuaded to blame another tier of government for any shortcomings resulting from funding restrictions.

Broadly speaking the Commonwealth currently takes responsibility for directly subsidising privately provided medical services (ie those provided in an out of hospital setting as well as in-hospital medical services for private patients whether in a public or private hospital – known as Medical Medicare); up to around 50% of public hospital services through the Australian Health Care Agreements (AHCAs - known as Hospital Medicare); pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS); private health insurance through the 30% rebate for provision of in-patient treatment to private patients as well as services provided by ancillary care providers in settings inside and outside hospitals; and residential aged care.

The State/Territory Governments are responsible for funding public hospitals including medical services, pharmaceuticals, medical devices and allied health services (together with the Commonwealth's contribution under the AHCAs and for private patients) as well as a range of community public health programs including communicable disease control, immunisation and harmful drug use prevention.

Unsurprisingly, the most intense disputation, cost and blame shifting between jurisdictions takes place close to the boundary lines between Commonwealth and State/Territory funding responsibilities. The community is more than familiar with the arcane definitional games that take place along these boundaries and the almost callous disregard to the collateral damage caused to ordinary people.

The shared nature of the responsibility for health funding between governments is also expensive. Some commentators such as Professor John Dwyer, Professor of Medicine University of New South Wales, have estimated that between $2b - $4b could be saved annually if the costs of duplication in administration and policy development carried on by Commonwealth and eight State/Territory governments could be eliminated and directed instead to public health measures.[1]

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[1] Dwyer J, *Moving from a Provider to a Patient-Focussed Health Care System: The Health Reform Imperative*, Health Issues, 2004, Number 81, pp.10-14

Whilst this term of reference relates to the boundaries between Commonwealth and State/Territory governments, it should also be kept in mind that similar boundaries exist in relation to public and private funding (including between private insurers and individual out of pocket expenses) and provision which adds further to the dynamics operating within the health system. Addressing boundary issues between public sector funders needs to take account of the other boundaries.

An interesting example of this interaction has followed the enhancement of the Medicare Safety Net in 2004 which provided for Medicare benefits to be paid for 80% of out of hospital medical charges incurred by individuals or families in a year once a particular threshold has been reached. In the case of obstetrics, bills that were given to and paid directly by the patient to the provider have now been transferred to the public sector. Depending on how the obstetrician structured their bills for the "global confinement and delivery" and what proportion was attributed to the "in-hospital" component, the introduction of the safety net has likely led to a re-apportionment of some in-hospital fees to out of hospital. There may also have been a transfer of some of the funding from private health insurers to Medicare.[2]

CHA considers that wherever there are multiple funders, it is almost inevitable that cost and blame shifting will follow. The only realistic way to reduce this likelihood is to reduce the number of boundaries between funders and where boundaries remain to ensure that they are as clear and precise as possible.

The most obvious way to reduce boundaries is to reduce the number of funders.

We would therefore propose a model where one tier of government takes responsibility for that part of the funding of the health system that is financed from the public purse. Whilst we would propose that one tier of government take responsibility for funding the health system, this does not necessarily mean that this tier of government would also be responsible for providing or operating the services. We would propose that service delivery would be undertaken by whichever organisation or agency could most effectively and efficiently provide the services – whether in the public (whether State/Territory, Commonwealth or Local Government) or private sector.

There is room for reconfiguration of health services along the lines of the model of aged care or the university sector - where Commonwealth funding and regulation provides a framework for the delivery of services by both private and public providers.

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[2] Generally health funds have reported that many obstetricians have apportioned their fees such that they have charged the maximum amount that a health fund would allow a practitioner to charge whilst still allowing access to health fund gap-cover scheme arrangements. The patient would then be charged the remainder of their fee directly as an out of pocket expense.

Some funds have only allowed obstetricians to access their gap-cover scheme if an obstetrician limited the global, total fee they would charge for the antenatal, delivery and post-natal services. The introduction of the Medicare safety net will have enabled obstetricians to escape from the strictures of health fund gap-cover rules and maintain their total charges by re-configuring their charges to increase their out of hospital charge (with Medicare picking up 80% of the fee) whilst maintaining or even foregoing participation in private health insurance gap-cover schemes.

The funding tier of Government would however take responsibility and be accountable for the overall cost and performance of the system.

In considering which tier of Government would be the most appropriate to take final responsibility, we acknowledge that each tier would bring different advantages or disadvantages. Some of these are set out below.

Table 1: Brief assessment of advantages/disadvantages of tier of government taking responsibility for health funding

Commonwealth

Advantages

- Can take an overall national perspective on health needs
- Would reduce administrative complexities for health care provider groups operating across several jurisdictions in having to deal with differing funding models and administrative arrangements
- Is best placed to promote good private sector practices in the public sector
- Has best access to financial resources (income taxes, GST etc)
- Already takes responsibility for aged care and private health incentives
- May be amenable to more flexible or alternative delivery mechanisms

Disadvantages

- Would result in a major concentration and centralisation of power and funding
- Would not be as sensitive to State/regional differences in needs and expectations

State/Territory

Advantages

- Already operate hospital systems – would have a better understanding of issues related to delivery
- Would be more sensitive to local/regional needs and expectations

Disadvantages

- Limited access to financial resources – substantially dependent on Commonwealth Grants Commission/GST funding
- May result in different level of health care provision across Australia depending on State/Territory financial position, priorities etc
- Administrative complexities for groups operating across several jurisdictions in having to deal with differing funding models and administrative arrangements

Whilst a move to a single tier of funding would not be without some problems, whichever tier of government became responsible, CHA considers that, given the depth of its own funding resources, the national approach that could be brought to bear and the existing responsibilities for the MBS, PBS and aged care, lead to the Commonwealth being the

logical choice. This would also be consistent with the trends in source of funds for health expenditure over recent years.

**Source of Funds - Australian Health Expenditure (Constant Prices)
1985-6 to 2002-03**

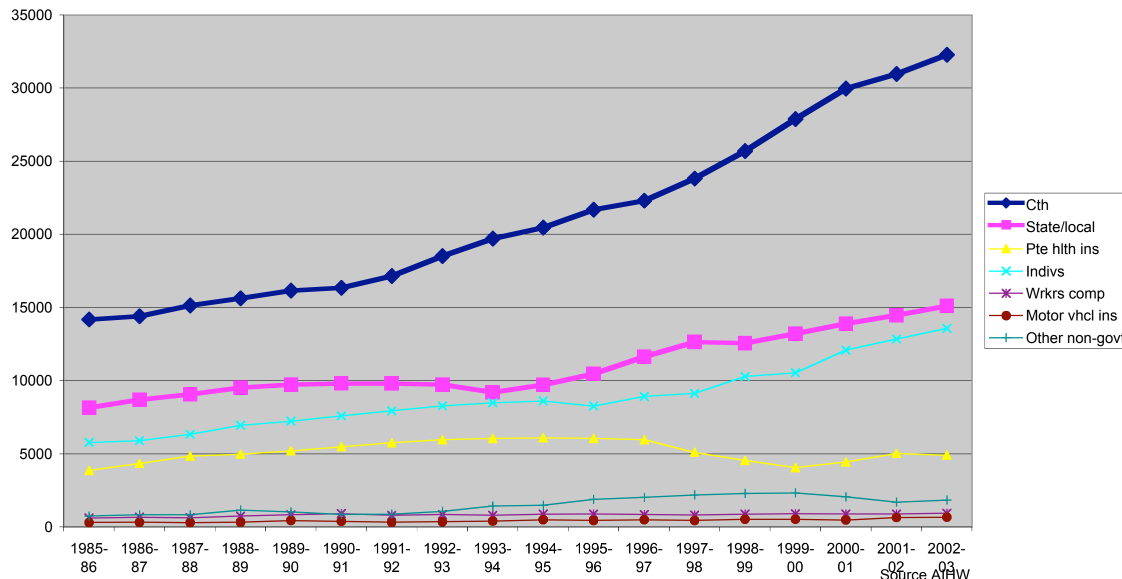

Figure 1: Source of Funds

Examination of funding arrangements also needs to have regard to the overall regulatory framework. Using private hospitals as an example, they are: licensed and accredited by States and Territories; are largely funded through private health insurance which is regulated and part funded by the Commonwealth; operate in a medical indemnity environment regulated (and part funded) by the Commonwealth; and are subject to building and planning regimes operated by local and State/Territory governments.

Table 2: Regulatory regime under which private hospitals operate

Tier of Government exercising regulatory authority	Commonwealth	State
Licensing/accreditation		Regulator
Private health insurance funding and regulation	Funder and regulator	
Medical imdemnity	Funder and regulator	
Building and planning controls		Regulator
Undergraduate training of doctors/nurses	Funder and regulator	Regulator
Post-graduate training of doctors/nurses	Regulator	Funder and regulator

Understanding the regulatory regime is crucial as regulatory changes have the potential to either enhance or thwart financial incentives that funders may introduce. In an ideal world there would be close alignment of both funding and regulatory arrangements. If the Commonwealth were to assume financial responsibility for the publicly funded component of the health system, then it should also have responsibility for the regulatory framework.

If the existing arrangements for financing health care continue to operate, then as Table 2 (above) indicates, the current regulatory framework will remain unnecessarily complex and inefficient. Those who have to operate within this framework understand that compliance with regulation is costly; compliance with dysfunctional regulation is even more so. CHA would therefore recommend that a joint Commonwealth State/Territory taskforce be established to review and rationalise the current regulatory framework that applies across the health industry. In undertaking its work, the taskforce should also have regard to the need for providers to be adequately funded to meet the costs of regulation.

Recommendations

That the Commonwealth should assume financial responsibility for all publicly sourced health funding (but not for the ownership of public hospitals, or the delivery of public hospital services

That regulatory arrangements governing health care provision should be examined by a Commonwealth and State/Territory taskforce with a view to creating greater alignment with funding responsibilities

Term of Reference 2

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

CHA's starting position is that a single tier of government should take on responsibility as the single public funder.

If this scenario cannot be achieved, there are a number of areas where some of the worst manifestations of boundary disputes could be ameliorated. These are addressed below.

Unnecessary hospital patients

The plight of elderly people who are unnecessarily trapped in expensive acute care facilities due to the lack of aged care accommodation has been well covered in the media.

The separation of funding responsibility between the Commonwealth and State/Territory Governments for aged care and acute hospital care respectively means there is little financial incentive for the Commonwealth as funder of aged care funding to spend money to expand aged care services which will have the effect of saving money for the States/Territories as acute care providers/funders. The outcome of these perverse incentives for the community at large is that there is a sub-optimal level of quality aged care accommodation available (as well as step-down and sub-acute facilities); and that which is available, is delivered in most expensive setting. For the individual being bounced between jurisdictions, it means the care they receive is too often delivered in the least appropriate setting.

Long Waiting Times

According to the State of Our Public Hospitals Report published by the Commonwealth in June 2004, in the five years from 1998-99 to 2002-03 on average across Australia, the proportion of public elective surgery patients who had to wait longer than the clinically appropriate time increased by 50% (from 10 % to 15%).[3] Whilst many on the waiting lists may not be suffering from life-threatening conditions, they may still be experiencing significant degradation of quality of life – often enduring chronic pain and lack of mobility and independence. Many of these are elderly and have been waiting for more than 12 months for treatment. For example, for ophthalmological procedures, in 2002-03, 9.5% of patients waited for more than 12 months – this figure was as high as 42.1% in Tasmania. For orthopaedic procedures, the national figure was 8.1% waiting in excess of 12 months – with 25.2% of orthopaedic patients in Tasmania waiting over 12 months.[4]

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[3] Department of Health and Ageing, *Source Data for The State of Our Public Hospitals June 2004 Report,*pp19-20

[4] Australian Institute of Health and Welfare, *Australian Hospital Statistics 2002-03*0, Table 5.4, p102

Reducing waiting lists is a complex problem requiring a combination of approaches ranging from preventive health; diversion to more appropriate settings (ie community, sub-acute, private etc); more resources for increased operations, nursing staff etc, greater efficiency (as evidenced by reductions in average lengths of stay); and removal of barriers to discharge (such as lack of appropriate sub-acute and aged care settings).

Medicare Seniors Plus

CHA is concerned that older people do not receive the essential care they need, when and where they need it. In the lead-up to the last Federal Election, CHA argued that extra resources should be dedicated to ensuring that older people were not left to linger on waiting lists for essential surgical and medical treatment and proposed its concept of Medicare Seniors Plus. CHA still considers that the concept of Medicare Seniors Plus has merit.

Under Medicare Seniors Plus, CHA proposes that people 75 years and older (and Indigenous people over 55 years) will be eligible, similarly to veterans, to access private health services, paid for by the Commonwealth. The Commonwealth would take the responsibility to ensure that older Australians receive timely access to essential care. As a major provider of private health care, the Catholic hospital system would be prepared to be a major partner with the Commonwealth in implementing such an initiative. Medicare Seniors Plus would ensure access to surgical and medical care within appropriate care and timeframe benchmarks. It will also ensure access and entitlement to other important and necessary health services such as dental care and rehabilitation after a period in hospital.

Medicare Seniors Plus would also alleviate some of the pressure on private health insurance and potentially lead to a reduction in premiums as some of the higher users of private health care will have their health needs met through the Medicare Seniors Plus arrangements.

Possible Direct Funding Trial

Catholic public hospitals have and continue to play a key role in the provision of public hospitals in a number of jurisdictions (Queensland, NSW, Victoria and the ACT) providing care through 2,500 beds in 22 hospitals.

Whilst the patients and the doctors, nurses and other health workers in those hospitals speak very highly of the services provided and the strong ethos of community responsibility evident in the way in which Catholic hospitals serve the community, it is clear that some State/Territory health bureaucracies are uneasy with the provision of public services by non-government owned entities.

It is CHA's belief that this uneasiness stems from too great a focus by State/Territory health departments on internal control and process management rather than health system outcomes. Catholic hospitals that sit outside State/Territory control networks don't quite fit the preferred model.

There are a number of Catholic public hospitals that would be willing to consider trialing a direct funding arrangement with the Commonwealth. The aim of the trial would be to demonstrate to the community the sorts of benefits that could accrue from a single funding approach. A trial could provide the opportunity to explore innovative approaches to achieving agreed outcomes as well as the chance to investigate opportunities arising from greater coordination of acute care hospital services, aged care and GP services.

Such a trial would need to be carried out with the involvement of the relevant State/Territory and would ideally cover the health services provided across a discrete geographic locality or region.

Recommendations

That the Commonwealth should take responsibility for funding the health care needs of elderly Australians aged over 75 through the implementation of Medicare Seniors Plus

That the concept of direct funding by the Commonwealth of public hospitals be explored through a pilot arrangement with a Catholic public hospital with the involvement of the relevant State/Territory

Term of Reference 3

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

One of the major problems with Australia's current health system and its multiplicity of funders is the lack of accountability that is engendered by the sheer complexity of the system. The media report to the public where the system may be failing or the cost to taxpayers of some services that are expensive, but beyond that there is little comprehension of who is actually responsible for providing those services. Additionally, much of the media commentary is negative and sensationalist - there is little reportage of the successes in the provision of health care to Australians.

With nearly 10% of Australia's GDP devoted to health care and just over 25% of this amount going to fund public hospitals, CHA considers that standards and timelines of accountability for this expenditure need to be tightened. To assist in improving the level of information and transparency available to consumers, CHA supports the annual publication of the State of Our Public Hospitals Report which was first published by the Commonwealth in June 2004. This publication provides, in readily accessible language, a useful comparison of hospital activity data, waiting times and costs across each of the States/Territories.

In addition to the annual publication of the State of the Public Hospitals report, CHA proposes that additional high level data be published (on the internet) on a more frequent quarterly basis by the Australian Institute of Health and Welfare. The data that we propose to have published – in a consisten format - for each jurisdiction would include:

- Activity (Episodes, days, DRGs)
- Waiting lists – numbers of people, waiting times (mean, median and maximum) by category
- An estimate of the cost of the above activity

We would propose that this information be published quarterly and within three months of the conclusion of the relevant quarter. This is similar to the requirement for private health data to be published quarterly by the Private Health Insurance Advisory Council (PHIAC) for private patient activity. The data would also allow for cross-jurisdiction comparisons to be made and would need to be based on consistent definitions.

At the moment, it is very difficult to access this type of information in an up to date and accessible format. The material that is available is often several years old and is formatted in a way, or uses definitions, which preclude ready comparability with other jurisdictions and has to be sourced individually from each jurisdiction.

Report Cards

One of the features that distinguishes health care from other goods and services is that consumers suffer a considerable disadvantage in terms of knowledge and access to

information about their treatment options and the relative performance of providers (doctors and hospitals) in delivering that treatment. Recent high profile revelations about the performance of some doctors and hospitals in several states and territories have reinforced for many consumers their need for greater comparative information. CHA strongly supports the rights of consumers to be able to make informed choices about their treatment and choice of provider.

Whilst the concept of report cards is undoubtedly attractive, in practice their preparation can be complex and can run the risk of creating unintended consequences[5]. The essential difficulty comes from ensuring that accurate comparisons are made between similar services. In particular, care needs to be taken to ensure that comparisons are only made between providers undertaking services of a similar nature and complexity in comparable environments. Clinicians and hospitals whose outcomes may be seen to be poor in terms of, for example, higher rates of mortality may in fact be those doctors and hospitals who are the most highly skilled and who happen to deal with the most complex and critical cases.

Risk rating schemes that are used to try to account for the various factors bearing on the risks associated with a particular patient's condition and prognosis, in the absence of intervention, are still in a process of evolution[6]. Apart from the always uncertain weightings of clinical factors and the patient's pre-existing medical history and co-morbidities, risk rating schemes need to take into consideration such factors as the patient's socio-economic background, support available to the patient as well as the resources and support available to the doctor and the hospital.

If providers perceive that a risk rating scheme may unfairly rate them due to the scheme not adequately accounting for factors that are beyond the providers' control, they may respond by declining to participate in the scheme and may become reluctant or even decline to treat those patients who constitute the highest risk and whose treatment may result in the provider being disadvantaged in the rating scheme. The effective operation of rating schemes may also be hindered by the current litigious legal framework, which acts to restrict information flow. This underscores the need for providers to be involved in the development and implementation of rating schemes.

Nevertheless, as recent events in Bundaberg, Queensland and in Bristol in the UK have shown, health care systems can suffer from serious lapses in safety standards. In the internet era of ready access to a large variety of information and performance standards in many industries, public confidence in the health care system can only be assured by the system being as open and transparent as possible.

We therefore propose that Health Ministers establish a task force to work with providers in developing a system of report cards that can be used to provide consumers with the tools they need to make informed decisions about their care. Based on experience from the US, such a system can also be expected to motivate providers to strive to match the peformance outcomes attained by their peers[7]. The development of report cards will

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[5] Thomas H. Lee, M.D., Gregg S. Meyer, M.D., and Troyen A. Brennan, M.D., J.D., M.P.H, *A Middle Ground on Public Accountability*, New England Journal of Medicine, Volume 350:2409-2412

[6] ibid, p2410

[7] ibid, p2410

need to have regard to the complexities involved in appropriately comparing the services offered by different providers to ensure that the report cards are not misleading and do not lead to unintended consequences such as the denial of treatment to the sickest patients.

Recommendations

That the Commonwealth publish annually a State of the Public Hospitals report

That the Commonwealth through the AIHW publish quarterly updates of activity in public hospitals within 3 months of the end of each quarter.

That Health Ministers establish a task force to work with providers in developing a system of report cards that can be used to provide consumers with the tools they need to make informed decisions about their care

Term of Reference 4

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

In considering this term of reference, it should be recognised, that whilst the private health industry as a whole has a common interest in working together to provide high quality, innovative and cost effective care to consumers, there will always be significant tensions between funders and providers; as well as between competitors – whether they are funders or providers. The inclusion of funders as part of the definition of the private health industry distinguishes it from other industries, which do not normally include funders. For this reason, Governments need to be realistic in their expectations of the extent that the "industry" as currently defined, will be able to, of its own volition, act as a cohesive whole. Given the inherent differences of financial interests, CHA contends that the Commonwealth Government, as a key stakeholder in the private health industry, can play a positive role in fostering greater industry dialogue.

CHA considers that it would be useful to establish an ongoing mechanism for private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government to meet on a regular basis to consider issues of industry wide importance to the private health industry. CHA would suggest that the Commonwealth is best placed to convene such meetings, which could be known as the *Australian Private Health Council*. This Council could meet say twice per year and its deliberations could be used to inform industry participants, as well as Ministers and their Departments, on developments within the industry and any policy issues or proposals arising from those developments which may need to be addressed.

Health Workforce

A particular issue that could be addressed in this forum is the health workforce. With the rapid expansion in the provision of private hospital services over the last five years together with the continuing increase in provision of public hospital services, the demand for clinically qualified staff has continued to increase at a much faster rate than existing supply. This imbalance has contributed to increased costs together with a restriction on the level of services that could otherwise have been provided by the private (and public sectors) in a number of specialties and geographic regions. Responsibility for funding, regulating and providing clinical and health related training crosses Commonwealth and State/Territory boundaries and will increasingly cross the public/private divide – making it an ideal topic for this proposed Council.

There are a number of other specific issues where better dialogue between the industry participants would assist the private health industry. These include:

Quality

There should be a standardised/co-ordinated industry approach to improving and managing quality. If funds pursue their own individual agendas/timetables, as is starting to be the case, there will be a significant administrative impost on hospitals (at a cost to government and patients) and a fragmented message to sell to consumers. CHA welcomes funds' interest in quality issues but funds should also recognise the work that hospitals have already put into the pursuit of quality.

CHA recommends that the Commonwealth should reinstate the Private Health Industry Quality and Safety Committee that was abandoned by the Department of Health and Ageing in 2004.

Payment models

We should work towards a rationalisation of funding models. The current array of payment models ranging from case payments through to pure per diem funding requires unnecessary additional administration and provides conflicting incentives which benefit neither patient, hospital, patient or funder.

Data collection

Hospitals are required to complete a range of data returns for different Commonwealth/State agencies as well as funds. CHA contends that we should work together as an industry to rationalise data collection in a way that meets the needs of all the different parties.

Robust cost collection and data analysis provide an essential foundation on which future efficiency can be built. CHA along with other industry stakeholders were therefore disappointed that the Department of Health and Ageing decided to cease funding the Private Hospital Cost Collection at the end of 2004.

CHA recommends that, at a time when the Commonwealth is contributing close to $3bn annually towards the 30% private health insurance rebate, it should reverse its recent decision to discontinue funding the Private Hospital Cost Data Collection

Electronic interface between hospitals and health funds

The private health industry needs to continue to work to rationalise electronic business interface between hospitals and funds including support and commitment to projects such as ECLIPSE (HIC electronic claiming and patient verification system).

Recommendations

That the Commonwealth establish and convene twice yearly meetings of representatives of private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government to be known as the *Australian Private Health Council* to consider issues of importance to the private health industry

That private hospitals and private health insurers establish a mechanism to address the issues of quality, payment models, data collection and analysis and electronic business processes within the private health sector

That the Commonwealth re-establish and fund the Private Health Industry Quality and Safety Committee (PHIQS)

That the Commonwealth reinstitute funding to enable the continuation of the National Health Cost Data Collection for the private sector

Term of Reference 5

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

This Term of Reference invites respondents to consider what the appropriate level of private health insurance membership in Australia should be.

As reported in an OECD study on private health insurance in 2004[8], there is a wide variation in OECD countries as to the scope and coverage of private and public health insurance - with the role of private health insurance ranging from "primary coverage for particular population groups to a supporting role for public systems" (see Appendix B). One of the conclusions that can be drawn from the study is that there is no particular right level of private health insurance within a health system that will simultaneously meet the aspirations of the population to access health services and contain costs.

Costs of running health care systems are rising across the OECD regardless of the mix of private and public provision – with the evidence pointing to systems with multiple primary insurers (ie public and private) and those with a greater proportion of private funding being more expensive – especially the US, Switzerland, Germany and France.

The particular design of individual program components is critical in determining outcomes and costs rather than whether they are privately or publicly financed and/or delivered. The interactions between public and private systems and the types of services that are covered by each or both insurance types also determine outcomes. Private finance and delivery is, of course, less subject to direct state control – including state imposed cost controls.

A significant proportion of consumers in the US, Canada, UK and Australia all report dissatisfaction with their own health systems[9]. As each of these countries has a different mix of public and private finance and provision, it is clear that the mix of public or private finance and provision does not of itself lead to better or worse performance of the health system.

It also appears that countries towards each of the extremes such as the US (private health insurance coverage of 72% of the population and responsible for 35% of the source of finance) and UK (private health insurance coverage of 10% of the population and 4% of the source of finance) seem to have greater problems than other countries. In

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[8] Colombo F, Tapay N, Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems, **OECD Health Working Papers No. 15 2004**

[9] Cathy Schoen, M.S., Robin Osborn, M.B.A., Phuong Trang Huynh, Ph.D., Michelle Doty, Ph.D., Karen Davis, Ph.D., Kinga Zapert, Ph.D., and Jordon Peugh, M.A., Primary Care and Health System Performance: Adults' Experiences in Five Countries, Health Affairs Web Exclusive (October 28, 2004) at http:www.healthaffairs.org

the US there are problems due to the large number of uninsured (40million) and high costs; in the UK rationing, waiting lists and lack of choice of providers result in dissatisfaction.

Having regard to the above discussion, CHA will not proffer a particular target level for private health insurance membership other than to suggest that somewhere in between either of the extremes of the US and UK is to be preferred. Whilst not nominating a particular target level for private health insurance membership, CHA considers that the health system is best served by having a level of private health insurance that is at least stable and provides access to a genuine range of choices of provider. This is most likely to be achieved by maintaining current levels of membership with some additional modest growth.

Turning more specifically to the Australian context, the preparation of this submission takes place in an environment where health fund membership, although displaying a reasonable degree of stability following the large membership increase in 2000 associated with the introduction of Lifetime Health Cover, is beginning to exhibit a number of the negative features of the 1990s. This includes an increase in the average age of private health insurance members which is contributing to increased claims and cost of claims on a per member basis (see Figures 1, 2 and 3). This is leading to increasing premiums and the tendency for the "better risks" (younger and healthier members) to leave thus reinforcing the negative cycle. Health fund members aged 65 and over on average claim around 7 times more in benefits than younger members. This ratio is likely to widen further as the costs of new and better forms of treatment resulting from improvements in technology continue to increase.

The Government's recent changes to increase the rebate for older people will add further to the pressures on health fund costs.

CHA contends that, in addition to whatever initiatives individual funds may take to improve their attractiveness in the market place, some changes in the policy environment will be required in order to at least maintain the total private health membership as well as increase the proportion of younger members with private health insurance.

One of the particular challenges in Australia in promoting private health insurance is the policy framework that promotes access to affordable private health insurance regardless of health status or risk – a policy which is supported by CHA. This means that health funds must insure all comers and cannot price discriminate on the basis of risk - the concept of "community rating". This is slightly modified by Lifetime Health Cover (LHC - see discussion below) but does not really detract from the reality that, even with increased loadings, the cost of private health insurance is not really aligned with the benefit that a purchaser is likely to derive from it.

Put simply, for younger healthier people, private health insurance is significantly more expensive than it would be if their premium was based on their actuarial risk to the health fund. By contrast premiums for older people are much cheaper than their actuarial risk would warrant.

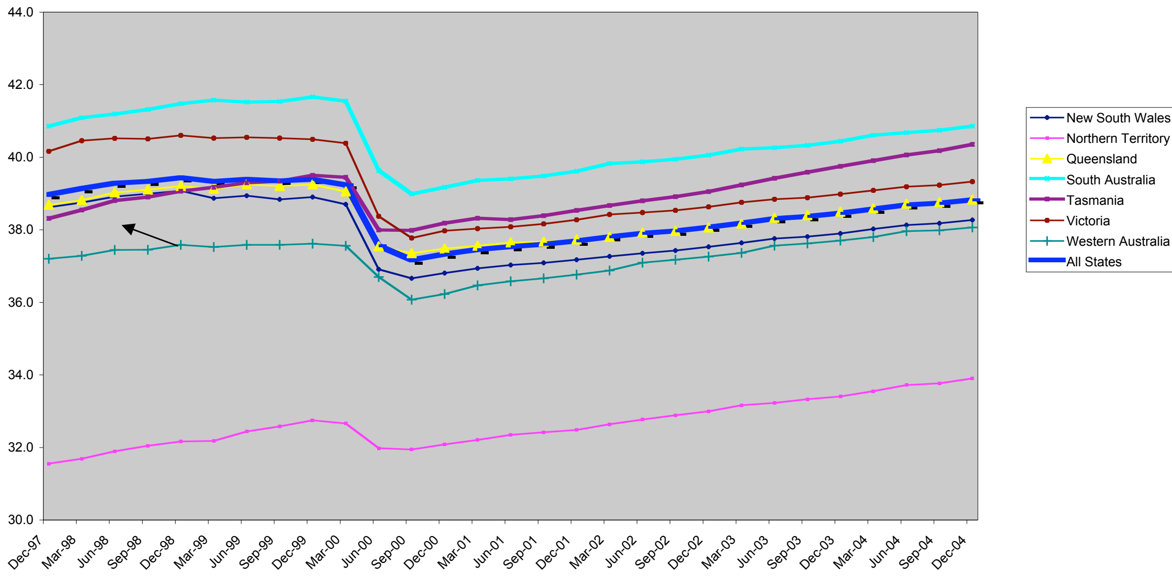

Figure 2 – Average Age of Private Health Insurance Members (Hospital Tables)

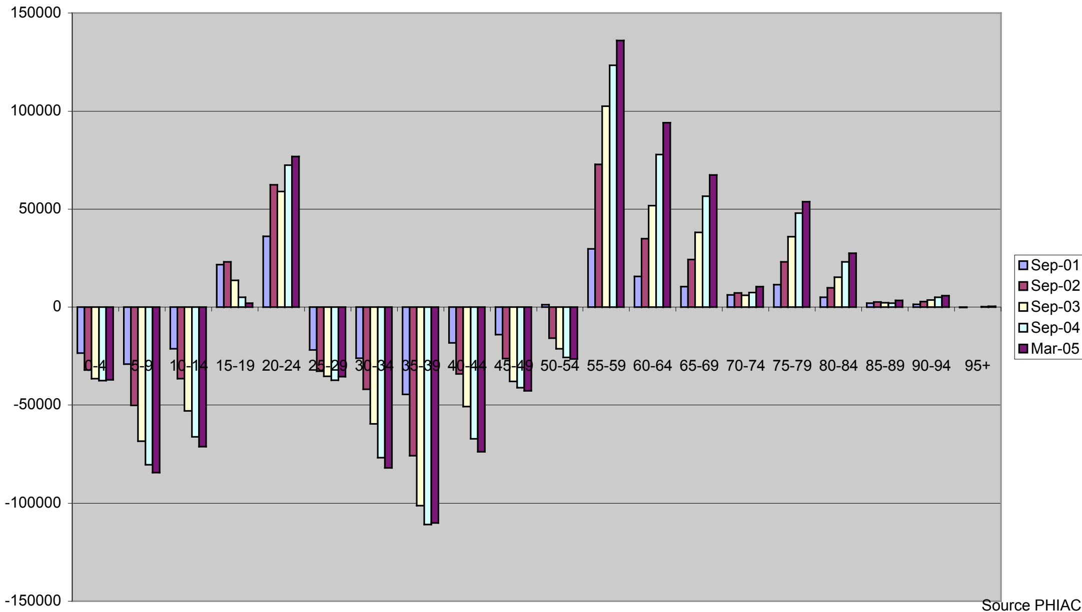

Figure 3 – Change in Hospital Table Coverage by Age Group since September 2000

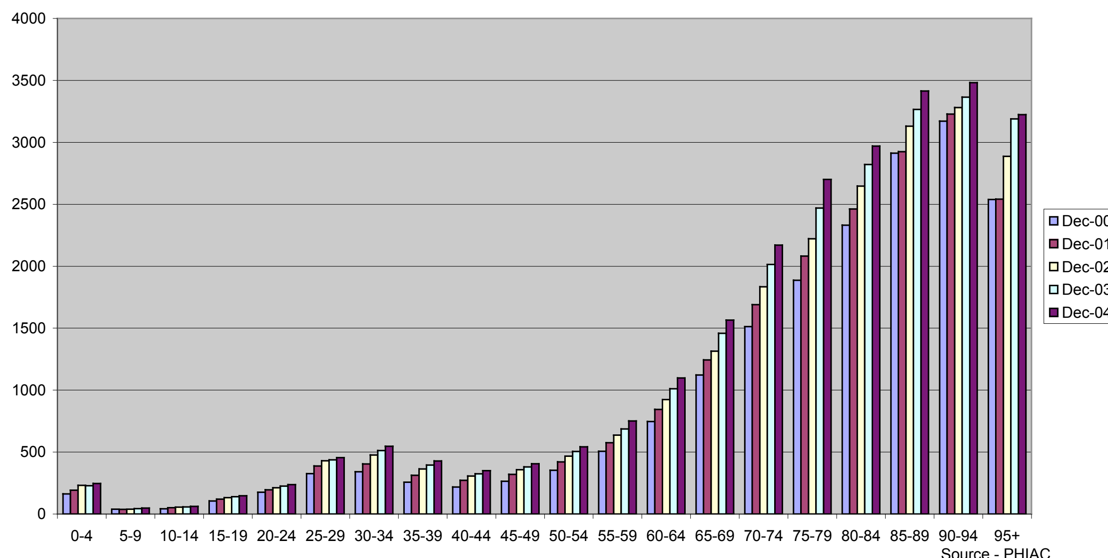

Figure 4 – Average Annual Hospital Table Benefit per Covered Member

Given the community rating policy framework, without further policy intervention, the process of adverse selection would kick in, as it has during the 1990s, with low risk members leaving and high risk members joining. The challenge is to create the right mix of policy that maintains community rating, whilst ensuring the continuation of incentives for low risk members to keep their insurance - thus keeping private health insurance affordable for all.

CHA notes from the experiences of the late 1990s that it is not always clear which particular policy intervention will have the greatest impact on membership levels. Both the tax surcharge for higher income earners and the 30% rebate were in place for some time with membership only slowly responding until the introduction of Lifetime Health Cover (LHC) in June 2000 (see Figure 5). Whether the introduction of LHC was pivotal or merely the final piece of the jig-saw that promoted a significant membership increase is a subject of ongoing and vigorous debate. Access Economics[10] argue strongly that it was the cumulative combination of the various positive and negative incentives that ultimately had the desired effect of increasing membership.

[10] Access Economics, *Striking a Balance, Report for the Australian Private Hospitals Association*, Canberra, 2002

It should also be noted that the adoption of CHA's Medicare Seniors Plus proposal (discussed above against Term of Reference (2)) would have the effect of removing a high cost cohort from private health insurance membership. The over 75 age group, whilst comprising 4% of the privately insured population, claim around 18% of benefits (PHIAC - December Quarter 2004)[11]. The removal of this cohort would allow premiums to fall for the remainder and thereby increase the attractiveness of private health insurance.

Percent of Population Covered by Private Health Insurance

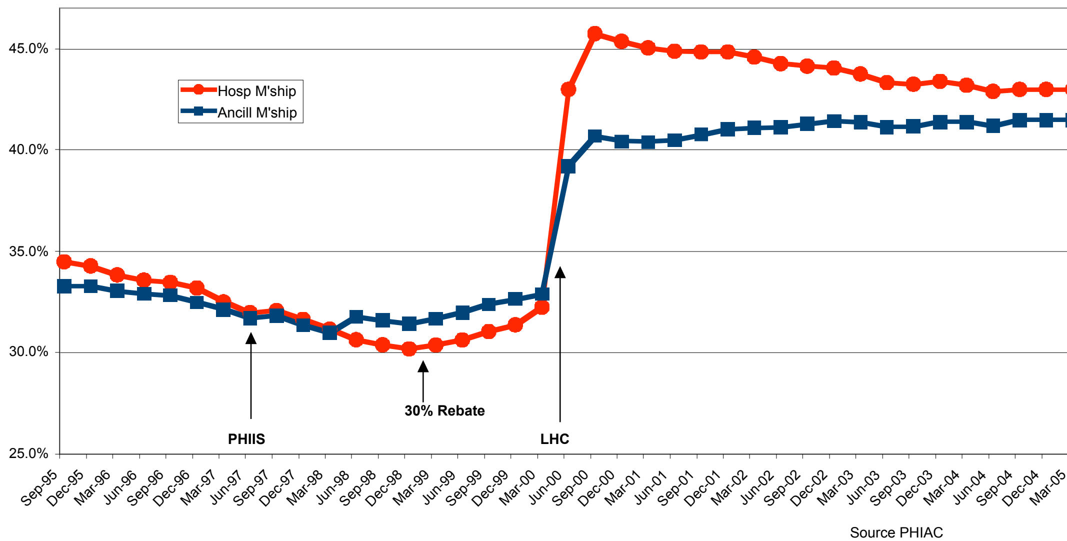

Figure 5 – Private Health Insurance Coverage (%)

A number of additional possible initiatives comprising both positive and negative incentives to join and maintain their private health insurance membership are set out below. CHA considers that the main impact of these proposals will be to maintain existing membership levels and in particular reinforce the continued participation of younger members.

<u>Higher tax surcharge for higher income earners who don't have private health insurance</u>

Currently there is a 1% tax loading on higher income taxpayers who do not have private health insurance. The tax surcharge cuts in at income levels of $50,000 for singles and $100,000 for families respectively. The effect of this tax surcharge is to encourage private health insurance membership by making it cheaper for people to take out private health insurance rather than pay the additional tax. As private health insurance premiums continue to rise, the differential between the dollar amount represented by the surcharge and the cost of private health insurance premiums will continue to erode. For

[11] Private Health Insurance Administration Council, *Statistics for December 2004*, at http://www.phiac.gov.au/statistics/membershipcoverage/index.htm

many of those at the lower end of the affected income scales it will increasingly become cheaper to pay the additional tax rather than purchase private health insurance. This discussion, of course, assumes that consumers do not derive any perceived benefit from purchasing private health insurance. However this policy setting is necessarily targeted at those for whom the perceived value of private health insurance is less than the cost of the premiums (even when reduced by the 30% rebate).

CHA considers that those with increased means should be provided with a greater incentive to contribute additional resources for their health care - either through an additional tax contribution or by taking out private health insurance. Increasing the surcharge to 2% would ensure that the incentive to take out private health insurance would not be blunted by further premium increases for at least the foreseeable future and will provide a strong additional incentive to those on higher incomes to take out private health insurance if they do not already have it.

According to the Australian Tax Office, in 2002-03, around 210,000 taxpayers were eligible to pay the Medicare surcharge – that is they were higher income earners who did not have private health insurance[12]. On average, they each paid a surcharge of $608. A doubling of the surcharge to over $1200 should render most private health insurance products an attractive alternative to paying the surcharge. If say a third of this group elected to take out private health insurance as a result of this change, and if each taxpayer represented say 2.5 individuals, the would increase private health insurance membership by 175,000 or 2%.

Such a change could be implemented - at the time of any reduction in marginal tax rates.

<u>Increase Lifetime Health Cover loading from 2% per year to 3%</u>

The introduction of Lifetime Health Cover (LHC) in June 2000 was associated with a 50% increase in membership from the March to the September Quarters (with coverage increasing from 32.2% to 45.7%).

CHA proposes that LHC be increased to 3% per year with effect from 1 July 2006. The period leading up to this date could be widely advertised with the aim of gaining a similar “big bang” increase of new members to that which occurred with the introduction of LHC in June 2000. It would be unlikely, however, that a similar effect to that of 2000 will be able to be repeated. Many of those who may have been influenced by this particular initiative will have already responded by taking out private health insurance in 2000. Additionally the quantum increase proposed in this submission is only half of the amount introduced in 2000.

CHA considered suggesting an increase in the LHC loading to 4% per year over 30 (a 4% escalation is the figure used by NZ private insurers and is closer to the actuarial increase in risk with age) but we were mindful of the risk of more or less permanently locking out potential members older than 30 who did not join before 1 July 2006 and who may be discouraged by the significantly increased premiums that would result.

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[12] Australian Taxation Office, Taxation Statistics – *A Summary of Taxation, Superannuation and Industry Benchmark Statistics 2002-03 and 2003-04*, p21

In proposing this measure, CHA recognises that consideration would need to be given to possible amnesty arrangements.

One option may be to waive the entirety of the LHC loading for all those who take out private health insurance before 1 July 2006, including the cohort that joined post-June 2000. According to the December 2004 PHIAC figures, around 3% of current members pay an LHC loading at an average rate of 22% (equivalent to joining at age 42). Provided an amnesty resulted in a membership increase of more than 1%, any reduction in contributions caused by the loss of the LHC loading should be offset by increased contributions from the additional members. There is a risk, however, that a complete removal of the LHC penalty may encourage a greater proportion of older age members to join which could lead to a deterioration of fund risk profiles within a short time period.

An alternative would be a partial amnesty – leaving say a 1% loading for each year of age over 30 for those who take out private health insurance prior to 1 July 2006. This would provide a greater incentive for younger people to join without being totally prohibitive to older people. This approach could be defended on equity grounds as still providing access to a product at below risk adjusted cost.

Remove the requirement for PHI premiums to be approved by the Commonwealth

The current simultaneous annual approval date for private health insurance premium increases, as well as restricting the ability of funds to meet the costs of providing care, also acts as an annual public relations nightmare for the private health industry (not to mention the Minister for Health and Ageing).

The political responsibility that the Minister has for ultimately approving premium increases means that the media are always going to be interested in running stories on increases – particularly given the way that the 30% rebate was sold as a means of keeping premiums down. In fact the current process provides several opportunities for bad publicity for private health insurance each year. The first opportunity is in mid-late December when news of health fund premium increase applications first appear – these stories can gain even greater prominence in the media "silly season" during the Christmas holidays. Further bad publicity is gained during March when the approved increases are announced and again in April when they actually come into effect.

In reality the statutory requirements for funds to maintain solvency and capital adequacy mean that the Minister's approval process is heavily constrained. A Minister faced with an application by a fund to increase premiums by 15% in order to maintain solvency is unlikely to deny the application and send the fund into liquidation.

The competitive nature of the market place means that funds are unlikely to seek increases above what is required to maintain solvency and make some small contribution to reserves. In fact historically many funds have had trouble even in setting premium levels that adequately cover the costs of their benefit obligations.

Another problem with the current system is its vulnerability to Ministerial gaming for political purposes. If a Health Minister wishes to make some mischievous short-term political capital, the higher increases sought by some funds could be "leaked" at an early stage. The Minister can then be portrayed as working hard on behalf of fund members

when the quantum of the sought increase is subsequently trimmed at the approval stage.

On another occasion, premium increases did not occur in the year prior to an election – only to have "catch-up" occur in the following – post-election - year.

One can only speculate as to how much individual health funds have at some stage been willing participants in this game.

It would be sensible for the industry if health fund premiums were de-regulated and removed from the sort of sensationalist scrutiny that accompanies a simultaneous increase in premiums by all funds as a result of a political approval process.

A competitive market underpinned by a well functioning portability framework where members can transfer their fund membership without loss of entitlement will ensure that premiums remain affordable (one of the objectives of the Government's 30% rebate). Private health insurance also has to compete with a public hospital sector where services are provided without charge at the point of service. In this regard, funds are acutely aware of the price elasticities of demand of their products and the consumer resistance to continuing premium increases. This will provide further downward pressure on unnecessary premium increases.

Notwithstanding our proposal for the de-regulation of premiums, funds will still be subject to the transparency requirements of the Private Health Insurance Administration Council (PHIAC) which already provides much more transparent information about health fund finances than do State/Territory Health Departments in relation to public hospitals. In the event that any fund starts to make what are regarded as excessive profits, this would rapidly become public knowledge and if resulting from higher than average premiums, fund members are likely to transfer their membership elsewhere.

Mandated share of PHI benefits to go to hospitals

The Commonwealth Government has a significant role to play in ensuring that private health insurance premiums and particularly premium increases are directed to meeting the direct costs of providing care in private hospitals. Using recent years as an example, the Government has been allowing annual premium increases in the order of 7 to 8% but in negotiations between the health funds and hospitals, the health funds are only offering to pass on to hospitals increases of less than 2% and in some cases reductions. In short, health costs are rising at up to 7-8% annually and hospitals have been meeting the shortfall. This is not sustainable. Since 1998 the share of private hospital benefits paid by health funds to hospitals has declined by 16% to being only 48% of the overall benefits paid to private health over the last year (see Figure 5). This represents a loss of $550 million on an annualised basis which could have been directed towards private patients' hospital costs and capital refurbishment and investment.

Under current arrangements, premium increases are granted by the Government on the pretext of funds needing to meet the real increases in costs of private hospitals. The Government needs to ensure that these increases are passed on, that those real costs

are covered by the funds, and that the value of Private Health Insurance is not eroded away. Health funds should be required to maintain a benchmark of at least 50% of benefits being directed to meet the costs of providing private hospital services (excluding prostheses and in-hospital medical services).

If this does not happen, and benefits are further eroded, the inevitable outcome will be higher out of pocket costs for private hospital patients.

Fringe Benefit Tax (FBT) Exemption for Employers

CHA is aware of proposals to exempt the purchase of private health insurance by employers for their employees from FBT liability. Whilst these proposals have the potential to increase fund membership, CHA has a number of concerns about the possible impact.

Firstly, it is not clear whether removing FBT would result in significantly more private health insurance members joining or instead would merely change the way that a large proportion of existing members purchase their health insurance and do so at additional cost to the taxpayer.

Private Health Insurance - components of rebate benefit - hospital and ancillary tables

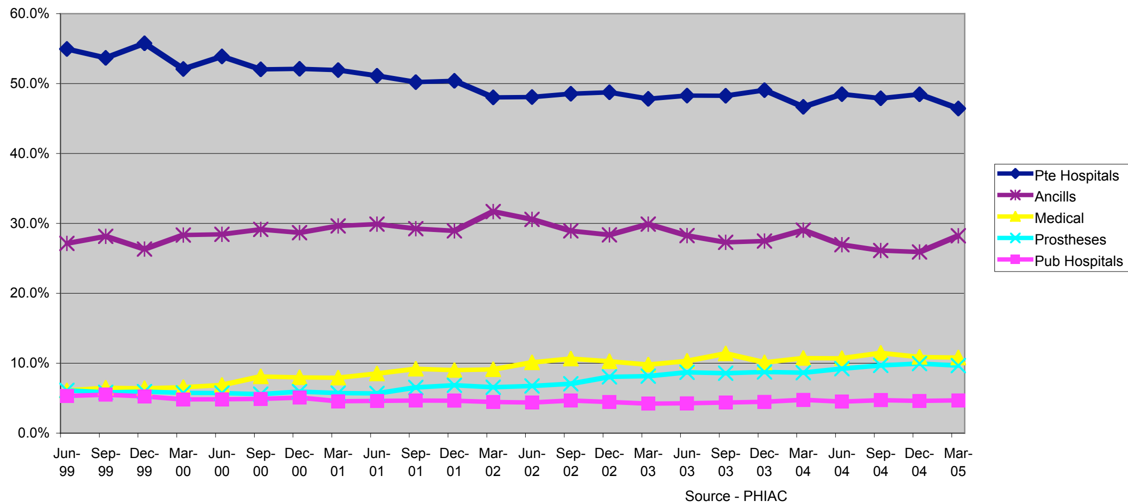

Figure 6 – Components of Private Health Insurance Benefits

With the large subsidy already provided by the Commonwealth for purchase of private health insurance through the 30% rebate, it is hard to argue persuasively for further subsidisation of private health insurance membership using this untargeted methodology - particularly if the impact on actually increasing membership is unclear. There are also

equity considerations as there a large number of people who may not be in a position to benefit from this change (ie the self employed, small business employees, pensioners, social security recipients etc). Even if the FBT exemption was restricted to new purchasers of private health insurance, over time the proportion of members purchasing health insurance through this method would increase (resulting in an ever increasing cost to the Treasury in the form of foregone tax) – especially if most of the beneficiaries would have bought private health insurance without this incentive.

In addition CHA is concerned about potentially adverse impacts that a measure directed to achieving a health financing objective could have on the operation of the labour market. In the United States, where private health insurance is generally paid for by employers, there are mounting concerns raised about the resulting negative impacts of linking health insurance to employment status. These include the coverage gaps that occur when employees change jobs or become unemployed, lack of coverage of the self-employed and small businesses. Also of concern is the impact of health insurance coverage on employees' willingness to change jobs if the health plan at the new employer is less generous than the one offered by the current employer and the consequent impediments to recruitment.

As a particular example of the US system, General Motors have recently indicated that they are seeking to achieve further savings from the health insurance premiums that they currently pay – indicating that each manufactured car carries a US$1,525 loading just to pay for current and future employee health insurance. (With the health care component costing more per car than the steel, GM claims that health care costs are placing them at a US$5billion per year disadvantage against their competitors). [13]. Increasing employer reluctance to pay the rising costs of health insurance is seeing the re-emergence of managed care initiatives in the US[14] and will ultimately restrict the private health insurance funded resources available for health care in that country.

Although the Australian health system is very different to that of the US (with private health insurance in Australia providing an add on complement to universal public coverage which does not exist in the US), CHA contends that we should be cautious about moving further towards a private health insurance system that becomes partially or wholly employer funded or otherwise linked to the workplace.

At this stage CHA recommends that FBT exemptions are not extended for payment of private health insurance.

Private Health Insurance Coverage (Hospital Tables) for some out of hospital services

An option that would increase the attractiveness of private health insurance would be to expand its scope of coverage. At the moment private health insurers are confined to offering coverage for in-hospital services (hospital tables). They can additionally offer coverage under ancillary tables for services out of hospital provided by allied health providers. Expanding the scope of coverage for the hospital table product may be perceived as offering greater value for members and potential members.

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[13] George Will "GM's Health Problems Partly its own fault", *Australian Financial Review* 2 May 2005, p63

[14] G Mays, G Claxton and J White,"Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies" *Health Affairs* 23, supplement no.2(2004):W4-427-436.

There are, however, a number of risks associated with expanding the scope of private health cover which warrant a cautious approach. Particular risks include:

- the dilution of the funds available in the private health insurance pool for providing core hospital benefits;

- the possible creation of incentives to change the setting in which a service is performed based on cost rather than clinical criteria; and

- the potential weakening of Medicare through the creation a dual health system where well resourced private health care is available for the wealthy and a sub-standard resource-starved public system must be relied upon by the remainder.

Given the diminution of the proportion of health fund benefits paid to hospitals that has already occurred under existing arrangements(see Figure 5 above), extension of private health insurance coverage could only be supported by CHA if it was clear that additional funding would be available to support additional services rather than being provided at the expense of existing services.

It is CHA's very strong contention that any extension of the scope of private health insurance should be done only in a context where there is continued commitment to the adequate funding of the universal public insurance system.

Rural and Remote Private Health Access

CHA notes that according to the Australian Institute of Health and Welfare, "Australians living outside major cities have shorter life expectancy, higher death rates, and are more likely to have a disability compared to city dwellers". For residents of rural and remote communities, private health insurance is a far less attractive product than for urban based Australians. Rural Australians have less access to the private sector than do their city counterparts. Private hospitals in rural areas face higher costs, lower volumes of patients (with a wide range of medical conditions), difficulties in attracting qualified health workers and inappropriate funding structures.

The Commonwealth Government's "Rural Private Access Program" aimed at enhancing the viability of rural and regional hospitals through funding service planning and capital equipment purchases has been of great benefit to many rural Catholic hospitals and should continue to be supported by Government. However, in terms of long term viability, funding for lump sum capital outlays and specific projects do not address the problem of a fundamentally flawed funding structure combined with the generally higher operating costs of rural and regional facilities – particularly in relation to freight, lack of economies of scale and large and variable casemix

Unless regional private hospitals are viable, consumers will have nowhere to use their private health insurance and medical services generally will continue to diminish in regional communities. CHA believes the Commonwealth has a continuing role to play in ensuring the ongoing viability of rural and regional private hospitals – either through

direct subsidy or through modifying existing private health insurance funding arrangements.

Allowing the Privately Insured to Opt Out of Medicare

CHA is aware of some proposals to allow those with private health insurance to opt out of paying the Medicare levy (and in some versions to opt out of the broader Medicare system). CHA would strenuously oppose such proposals.

CHA strongly supports a continuation of the universal health insurance system, Medicare. The universal nature of Medicare enables it to achieve both equity and efficiency goals that would be weakened by a loss of universality. The enrolment of the entire Australian population in Medicare allows the attainment of economies of scale – particularly in relation to administration and the provision of some areas of high technology medicine. Any reduction in the population covered by Medicare could lead to increased fragmentation and duplication of services.

From an equity perspective, CHA would be very concerned to avoid the creation of a two-tiered system where the well-off can afford to purchase high quality health care and the less well-off are forced to use an impoverished public system. The universality of Medicare means that the most articulate and powerful in society have a vested interest in ensuring that the level and quality of service provision in the public system does not decline. Additionally any reduction in the universality of Medicare will necessarily see some people fall through the cracks and end up without coverage at a time when they most need it.

CHA supports the continuation of the ability for people to choose to purchase access to choice of provider – whether through health insurance or directly – but only on the basis that the universal coverage provided by Medicare is not eroded.

Recommendations

That the Commonwealth increase the surcharge on higher income earners who do not have private health insurance to 2%

That the Commonwealth increase the Lifetime Health Cover loading to 3% per year over 30

That, whilst maintaining the 30% subsidy for consumers to increase the affordability of private health insurance, the Commonwealth de-regulate health insurance premiums

That Fringe Benefits Tax continue to apply to payment of private health insurance premiums

Health funds should be required to pay private hospitals a benchmark for the cost of private hospital services (excluding prostheses and in-hospital medical services) of at least 50% of all benefits paid.

That Medicare is retained as a universal system with no opt-out option available for private health insurance members

That the Commonwealth and private health industry examine ways to improve the value of private health insurance membership in rural and remote areas.

Appendix A

CHA Foundational Principles

The Catholic health, community and aged care ministry is defined by these interrelated foundational principles:

Dignity: Each person has an intrinsic value and inalienable right to life. Everyone has a right to essential comprehensive health care.

Respect for Human Life: From the moment of conception to natural death, each person has inherent dignity and a right to life consistent with that dignity.

Human Equality: Equality of all persons comes from their essential dignity. While differences are part of God's plan, social and cultural discrimination in fundamental rights are not part of God's design.

Service: Health care is a social good. It is a service, not a commodity used for maximising profit.

Common Good: Social conditions should allow people to reach their full human potential and to realise their human dignity. Equitable access to care, developing research and training, and conducting professional inquiry into the social, ethical and cultural aspects of health, builds social conditions and communities that respect human life and allow people to realise their potential.

Association: Every person is both sacred and special. How we organise society – in economics, politics, law and policy – directly affects human dignity and the capacity of individuals to grow in community.

Preference for the Poor: Priority must be given to the needs and opportunities of the poor and disadvantaged. This encompasses economic, cultural and individual notions of poverty and disadvantage.

Stewardship: Health resources should be prudently developed, maintained and shared in the interests of the community as a whole and balanced with resources needed for essential human services.

Subsidiarity: The identified needs of individuals and the community are best addressed at the level where responses and resources are available, appropriate and effective.

Appendix **B**

Scope and Coverage of Private Health Insurance – Comparison of OECD Countries

	PHI (% of total health expenditure)	Population covered by PHI (%)	Types of private coverage		PHI (% of total health expenditure)	Population covered by PHI (%)	Types of private coverage
Australia	7.3	44.9 40.3	Duplicate, Complementary Supplementary	Korea	n.a.	n.a.	Supplementary
Austria	7.2	0.1 31.8	Primary (Substitute) Complementary, Supplementary	Luxenbourg	1.6	2.4	Complementary, Supplementary
Belgium	n.a.	57.5	Primary (Principal) Complementary, Supplementary	Mexico	2.5 (2001)	2.8	Duplicate, Supplementary
Canada	11.4	65(e)	Supplementary	New Zealand	6.3	35	Duplicate, Complementary Supplementary
Czech Republic	0(e)	negligible	Supplementary	Norway	0(e)	negligible	n.a.
Denmark	1.6	28 (1998)	Complementary, Supplementary	Netherlands	15.2	92 *of which* 28.0 64(e)	Primary (Principal) Supplementary
Finland	2.6	10	Duplicate, Complementary Supplementary	Poland	n.a.	negligible	Supplementary
France	12.7	92	Complementary, Supplementary	Portugal	1.5 (1997)	14.8	Duplicate, Complementary Supplementary
Germany	12.6	18.2 *of which:* 9.1 9.1	Primary (Substitute) Complementary, Supplementary	Slovak Republic	0(e)	negligible	Supplementary
Greece	n.a.	10	Duplicate, Supplementary	Spain	3.9	13 *of which:* 2.7 10.3	Primary (Substitute, Principal) Duplicate, Supplementary
Hungary	0.2	negligible	Supplementary	Sweden	n.a.	negligible	Complementary, Supplementary
Iceland	0(e)	negligible	Supplementary	Switzerland	10.5	80	Supplementary
Ireland	7.6	43.8	Duplicate, Complementary Supplementary	Turkey	0.7 (1994)	<2	Complementary, Supplementary
Italy	0.9	15.6 (1999)	Duplicate, Complementary Supplementary	United Kingdom	3.3 (1996)	10	Duplicate, Supplementary
Japan	0.3	negligible	n.a.	United States	35.1	71.9	Primary (Principal) Supplementary, Complementary