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Minister for Health

555 Collins Street
GPO Box 4057
Melbourne Victoria 3001
DX210081
www.dhs.vic.gov.au
Telephone: (03) 9616 8561
Facsimile: (03) 9616 8355

e384051

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Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
Parliament House
CANBERRA 2600

Dear Committee Secretary

VICTORIAN SUBMISSION TO THE INQUIRY INTO HEALTH FUNDING

I refer to the Standing Committee on Health and Ageing's call for submissions to the Inquiry into Health Funding.

Australia's health system, with Medicare at its centre, is one reason why health-adjusted life-expectancies in Australia are among the highest in the world. Medicare, which was founded on the basis that quality health care should be available to all who need it, not just those who can afford it, is consistently rated by Australians as one of the most important tax-funded services that Governments provide.

Not only is good health needed for people to be able to lead individually fulfilling lives, it impacts on the productivity of our workforce, the resilience of our families and communities, and even our international competitiveness.

But as the Productivity Commission has argued in its recent progress report on medical technology, population ageing and strong community expectations that new technologies should be accessible to all, will increase pressure on health systems, posing challenges for governments, private insurers and the community generally. The Victorian Government therefore welcomes this inquiry, and also the decision of the Council of Commonwealths (COAG) to examine a range of options for reforming Australia's health care system. While this submission covers some aspects of the COAG agenda, Victoria is also closely engaged in working through all of the issues that are part of the agreed COAG process.

Increasing the health system's focus on prevention and health promotion

In revealing many of the underlying causes of disease, much medical and social research points to the health gains and system efficiency improvements that stem from prevention, early intervention and health promotion programs. While this is widely recognised in the wider community, translating such knowledge into effective action generally requires concerted action across sectors, including non-health sectors.

Unlike many advances in curative care, which often entail refining or extending things that the health care system is already adept at doing, most strategies aimed at addressing the

underlying causes of ill-health have no ready-made delivery system. Part of the difficulty of coordinated cross-sectoral action, is striking the right balance between health sector and non-health sector public health interventions. Health sector interventions include regulatory controls, health screening, public education and financial incentives; and interventions delivered by other sectors include employment and economic development, education, community connectedness and reduction of social inequalities. Victoria's primary care partnerships, and the *Neighbourhood Renewal* program are examples of Victorian Government 'joined-up' initiatives with a strong prevention and health promotion emphasis.

The establishment of the National Public Health Partnership (NPHP) by Australian Health Ministers in July 1996, following endorsement by COAG the previous month, was also a significant step forward. The NPHP established, for the first time, a multilateral, inter-governmental framework between the Commonwealth and state/territory health authorities to protect and improve the health of Australians.

However an evaluation undertaken in 2002 found that while the NPHP undertook a wide range of developmental activities and projects, it had only limited success in translating its work plan into policy and practice across jurisdictions. This results, in part, from the NPHP's lack of capacity for implementation of public health programs which remain the responsibility of each jurisdiction. The role of the NPHP is limited to the provision of frameworks of best practice, model provisions and public health capacity building, and as a result it is not able to provide national leadership in public health. Other countries have large national public health organisations with responsibility for funding or implementing national public health interventions including the Canadian *Public Health Agency*, the US *Centers for Disease Control and Prevention*, and the UK *Health Protection and Health Development Agencies*.

Under the current arrangements there is also little linking of the work of the NPHP with the Public Health Outcome Funding Agreements (PHOFAs), which are the principal funding arrangement between the Commonwealth and the states/territories for public health matters. In the lead up to the signing of the third set of PHOFAs in 2004, state and territory health ministers argued, amongst other things, that the new agreements should provide funding to allow increased program coverage, however this did not eventuate.

Clearly, work would be needed to refine the nature and *modus operandi* of a national public health institute, and how it would interact with existing structures and processes. However, the agreement at COAG in June to work towards improving the integration of the health system and increase the health system's focus on prevention and health promotion provides an opportunity to start this process.

Increased investment in health promotion and ill-health prevention not only offers the prospect of reducing future costs to individuals and to the taxpayer, but is also an essential part of reducing social disadvantage and giving more people the opportunity to fully participate in the life of our community.

Hospital services

The Committee's terms of reference require it to have regard for Australia's strong mix of public and private funding and service delivery. Public hospitals are a central part of this mix:

- All specialist children's hospitals are public
- Almost all neonatal intensive care services are in public hospitals
- Almost all organ transplants occur in public hospitals
- Almost all clinical training takes place in public hospitals
- In most regional and rural areas, the only local hospital is public
- 68 per cent of all non-sameday separations are from public hospitals
- 90 per cent of accident and emergency occasions of service are provided in public hospitals.

Over the past decade the role of the private sector in the provision of hospital care in Australia has grown strongly. For example, the growth in private hospital expenditure combined with medical expenditure on private admitted patients is estimated to have contributed one sixth of

the 1.3 percentage point rise in national health expenditure from 8.2 per cent of GDP in 1992-93 to 9.5 per cent in 2002-03. Over the same period the share of GDP going to public hospitals has actually fallen.

Estimates presented in the Victorian Department of Human Services submission to the Productivity Commission's research study of medical technology indicate that on a casemix-adjusted basis, and taking into account several of the above differences, total unit funding for private admitted patients (excluding DVA-funded and accident compensation patients) in 2002-03 was around 7 per cent higher than for public inpatients. This margin swelled to around 16 per cent when private health insurance management overheads of around 10 per cent are included. These estimates are based not only on the hospital-related costs of the 30 per cent private health insurance rebate, but also well over $1 billion in MBS benefits, plus PBS costs for admitted patients in private hospitals.

Including MBS benefits, the Commonwealth is estimated to be now contributing almost 40 per cent of total private inpatient costs, a level that will rise further when the increased private health insurance rebates for older people takes effect. This may well mean that on a casemix-adjusted basis the Commonwealth subsidy for privately insured patients would exceed its funding support for public patients through the *Australian Health Care Agreements* (AHCAs).

In 2003-04, recurrent expenditure by public hospitals, excluding depreciation, amounted to $20.0 billion as reported in May 2005 by the *Australian Institute of Health and Welfare*. $1.6 billion was from non-government revenue sources, including individuals and private health insurance funds. Of the remaining $18.4 billion, the Commonwealth provided $7.5 billion through the AHCAs, plus a further $0.3 billion for highly specialised drugs and $0.7 billion for treating veterans. The remainder – almost $10 billion - represents state and territory government funding. Since state and territory governments also provide the vast bulk of capital funding for public hospitals this means that more than half of all public hospital funding in 2003-04 was provided by state and territories. While the Commonwealth also contributes in other ways to the provision of public hospital services, including through its 63 per cent share of funding under the National Blood Agreement, these extra streams of funding do not alter the basic picture.

Independently verified figures for Commonwealth and State Government funding for Victorian public hospitals, submitted as a requirement of the current AHCA, show the Commonwealth Government's share of funding has declined from 49 per cent in 1998-99 to 42 per cent in 2003-04. On current estimates, the Commonwealth's share in 2004-05 could be as low as 40 per cent.

Inadequate cost indexation and inadequate allowance for demand growth are the main reasons for the decline in the Commonwealth's share of public hospital funding. The cost indexation is likely to become even more inadequate once responsibility for establishing a minimum wage passes to the proposed *Fair Pay Commission*, since the annual safety net judgement by the AIRC is the main ingredient in determining the indexation rate.

If the Commonwealth's position had been accepted by the AIRC in the 2004 national wage case the 2004-05 cost indexation factor would have been only 1½ per cent. This would have been at a time when enterprise bargaining has led to wage increases across all industries and sectors of close to 4 per cent nationally, and with non-wage costs in the health sector running well ahead of CPI growth of around 2½ per cent.

While Commonwealth support for private health insurance via the 30 per cent rebate has clearly made private health insurance more affordable, the Victorian Government does not agree that that this is the most cost-effective path for the health system to follow, or that it has alleviated pressures on public patient services.

A review of the international evidence by the Canadian Health Services Research Foundation (CHSRF) in March 2005 finds no support for the claim that running a parallel private health

insurance system reduces waiting times in the public system[1]. Indeed, the CHSRF finds that public waiting times may actually increase[nl]. Reasons cited for this include the fact that many specialists practice in both the public and private sectors, and since their income from private patients is greater, they have an incentive to keep public waiting lists longer in order to encourage people to opt for private care. Over time more specialists will seek to move their whole practice to the private sector, and this can then lead to recruitment difficulties – and increased waiting times - in the public sector. Training of specialists involves long lead times and structural bottlenecks and this further compounds the workforce supply problem.

A recent paper that examined trends in public and private hospital admissions in Victoria from 1998-99 to 2002-03 gave another reason why increased private insurance levels can lead to increased pressure on public hospital waiting lists:

> *An explanation for this effect is that the availability of health services changes decision making process by clinicians, that is, if a service is seen as readily available it is more likely to be recommended to the patient amongst a variety of treatment options. If elective surgery is seen as readily available, then clinicians are more likely to recommend surgery than a less aggressive treatment regime, or even adopting a 'wait and see' approach. Under such a hypothesis it is even possible that, in the longer term, the increased use of private hospitals by the privately insured may result in increased pressure on the public sector through changed clinical practice.* [2]

Furthermore, most of the increase in private health insurance resulting from the Commonwealth's health insurance changes has been among younger people, with the proportion of people aged 70 and over with private coverage rising only 3 percentage points since 1998 (to 39 per cent) compared to a 14 percentage point rise (to 44 per cent) for people aged under 70. This may change as a result of the increased subsidy for older people that commenced this year, but based on the most recent data available (March 2005) this seems unlikely.

It is also important to note that the increase in health cover was only achieved after the introduction of lifetime health cover, not the introduction of the 30 per cent rebate. Lifetime health cover was designed to encourage younger people to insure, with the result that any substantial impact on public hospital demand is likely to be very long term as the young newly insured grow old.

The conclusion from this - that the public sector is bearing more of the cost of treating older, and so generally sicker, patients - is borne out by the evidence. For Victoria, hospital admissions data show that between 1998-99 and 2003-04 there was a 23 per cent jump, measured on a case-weighted basis, in the per capita admission rate for private patients (excluding DVA-funded and accident compensation patients) aged 40-69, while for private patients aged 70 and over the rate rose by only 8 per cent. Conversely, the case-weighted admission rate for public patients aged 40-69 remained unchanged, compared with a 9 per cent growth in the rate for public patients aged 70 and over.

Also, as the Productivity Commission argued in its April progress report on medical technology, insured patients tend to access new medical technologies ahead of public patients, so helping push up costs. For example, drug-eluting coronary stents (DES), which are more than double the cost of bare metal stents, are reportedly used in 90 per cent of privately-insured patients undergoing coronary angioplasty. By contrast, in Victorian public hospitals a policy was developed in conjunction with cardiologists to ensure DES were used for public patients only where research evidence pointed to their clinical effectiveness, and they are currently only used in around 50 per cent of cases.

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[1] Canadian Health Services Research Foundation. 2005. *Myth: A parallel private system would reduce waiting times in the public system.* See www.chsrf.ca

[2] Sundararajan V, Brown K, Henderson T, and Hindle D. 2004. *Effects of increased private health insurance on hospital utilisation in Victoria.* Australian Health Review. 28:320-329

The Commonwealth's Medicare safety net represents, in part, further support for private health insurance. The majority of the safety net expenditure is for specialised services, not GP visits, and a large proportion are for services that relate to a subsequent (or previous) hospital admission. Many are the kind of services that are provided on an outpatient basis in public hospitals.

As much as perhaps half the safety net expenditure may relate to these services, and because this reduces out-of-pocket costs for treatments that span both inpatient and outpatient components, it helps improve the attractiveness of private health insurance. But since the Commonwealth has little control over doctors' fees or service levels, this policy is proving costly. During 2004, total charges for those specialist services, excluding pathology, that are provided mainly to non-admitted patients grew by 10 per cent from $3.84 billion to $4.22 billion, the fastest growth in many years and well above the average annual growth over the previous decade of 6.3 per cent.

If this high growth in doctors' charges persists, the cost of the safety net could still rise despite the higher thresholds in 2006.

In the absence of controls over doctors fees and servicing levels, this rapid cost growth could continue if private insurers were given an unfettered right to cover the cost of services for non-admitted patients as the Australian Health Insurance Association has proposed in its submission to this inquiry.

The Victorian Government's concern about the growing cost of the Commonwealth's support for private health insurance is based on past experience, with the Commonwealth's original *Fairer Medicare* initiatives having been implemented at the same time as a cut in public hospital funding of $918 million over 4 years, or $1.3 billion over the life of the current AHCA.

Subsidies for private health insurance at the expense of publicly-provided health services is also likely to shift the balance of health resources away from services that are heavily used by some of the most disadvantaged groups, such as public dental services, mental health services and drug and alcohol treatment services.

General practitioner services

The Victorian Government is pleased to see that the Commonwealth's bulk billing incentives and *100 per cent Medicare* initiative have led to bulk billing rates for GPs reaching their highest level in 2½ years. The rise in bulk billing in rural and regional Victoria, which has jumped to its highest level in 4 years, is particularly welcome.

The Victorian Government also strongly supports the range of other initiatives adopted by the Commonwealth to improve access to GP services. These initiatives, include:

- The establishment of GP clinics co-located with public hospitals, with the clinic at The Northern Hospital now operating
- Improved incentives for GPs to see patients in aged care facilities
- More after-hours clinics in regional and outer suburban areas and higher rebates for GPs to see patients after hours, and
- Incentives for GPs to set up practices in metropolitan growth areas, and in regional and rural areas.

24 hour call centres are another way of dealing with the primary care load on hospital emergency departments and the Victorian Government welcomes the agreements at COAG to lift the priority given to the development of a National Health Call Centre Network.

However, affordability of GP services also remains a concern, despite the higher rebates now available. As already noted, the existing safety net has only a minor impact on GP services, and this will further diminish when the thresholds rise next year. Published Medicare statistics show that despite the safety net and the increase in bulk-billing brought about by the Commonwealth's $5 and $7.50 incentive payments, out-of-pocket expenses for non-bulk billed

GP visits continue to rise. In the March quarter 2005, 75.4 per cent of non-referred attendances were bulk billed, the same level as in the March quarter 2002. However over that time the average co-payment for non-bulk billed services has risen from $11.80 to $15.30, a jump of 30 per cent.

Increasing patient costs for GP visits has the potential to counteract the benefit of initiatives that would otherwise be expected to take some of the load off hospital emergency departments from primary care type patients seeking emergency department treatment.

Rural health services

While there are differing views on whether pooling of all state and Commonwealth health funding at a regional level would help solve the problem of system fragmentation, for rural health services the case for greater funds pooling is very strong. This was recognised some years ago (1993) when the Commonwealth and states jointly created the multi-purpose services (MPS) program. This program has proved very successful in enabling some small rural health and aged care agencies to adapt their service mix to meet community needs within a flexible funding framework. Seven MPSs were established in Victoria in the early years of the program, but the cash-out rate for aged care has fallen behind the growth in service delivery costs and so no new MPSs have been created in Victoria for several years.

In 2003, the Victorian Government took a further step down this path with the adoption of *Small Rural Health Services* (SRHS) policy. The policy involves the pooling of all Victorian government health and aged care funding for 66 rural health services across the State. The approach gives small rural health services the flexibility to direct funding to the mix of services that will best suit the needs of their local community.

The SRHS approach enables funding and service delivery flexibility with a local focus in towns with fewer than 5,000 people. It encourages services to be active in the planning and management of health service delivery to meet local needs, to involve the community and to be active in collaborative planning and service delivery arrangements with neighbouring health service providers.

While there is strong collaboration between the Australian Department of Health and Ageing and the Victorian Department of Human Services in the implementation of the Commonwealth *Rural Primary Health* program, the Victorian Government believes that further gains may be possible if Commonwealth and State funds directed to rural areas were combined in a larger and more flexible funds pooling scheme in which the Commonwealth recognizes the real costs of aged care service delivery.

Such an approach could also address the longstanding problems that exist for many small rural hospitals where the local GP is also the hospital's medical officer, and the hospital is sometimes called upon to provide services, at no charge, that in larger communities would fall fully within the Medicare Benefits Scheme. The Victorian Government is pleased that one of the outcomes of the June COAG meeting is work to address the specific challenges of service delivery in rural and remote Australia.

Aged care

Victoria welcomes the steps that Commonwealth has taken in recent years to improve and expand the provision of aged care service, particularly community-based and home based care, and to help develop new ways of ensuring that older people do not remain in hospital longer than necessary.

Specific initiatives include the mainstreaming of Extended Aged Care in The Home (EACH), the *Pathways Home* program under the AHCAs, the development of the transition care program, higher Medicare rebates for doctors seeing patients in residential aged care facilities, the establishment of the *Community Care Review* and, most recently, the announcement on 27 June of additional one-off funding for residential aged care.

However, while these initiatives are welcome, overall service growth is still failing to match the growth in demand. The provision ratio for high care residential places in Victoria has continued to deteriorate over the last decade – a matter that has been raised many times with the Commonwealth. The ratio of high care provision in Victoria has fallen in every year since 1985 (when there were 54.4 high care places per 1000 70+) and fell below the benchmark in 2000.

The ratio of operational places for high care in Victoria is 38 places per one thousand people 70+ against a planning benchmark of 40 places. This is of real concern as it fell again in the year to 30 June 2004. Victoria requires over 900 more high care residential beds to meet the current planning ratios.

While bringing on line approved but not yet operational places would make a difference, the real demand for high care places is greater than the planning ratios indicate. NSW has 45 high care beds per 1000 people over the age of 70 more than Victoria (a difference of 18 per cent) yet still has similarly high occupancy rates. On the other hand, occupancy rates for low care are well below the planning ratios and still falling, in part because the expansion of Community Aged Care Packages (CACPs) and HACC has allowed people to stay much longer in their own homes.

The other key concern of the Victorian Government is the very low growth that has been available for HACC in Victoria since the commencement of the HACC equalisation strategy in 1996. Despite the growth in CACPs, the demand for HACC services continues to outstrip the available funding. The equalisation strategy did not recognise that a key reason for higher HACC service levels in Victoria was the lower provision of residential aged care places. The strategy favours jurisdictions that rely more on the higher cost (and primarily Commonwealth funded) option of residential care, and penalises the more efficient and client focused approach of encouraging people to remain in their own homes with appropriate support.

This is compounded by the fact that, as with hospital funding, the cost indexation factor allowed by the Commonwealth for HACC is well below the growth in service provision costs. Like most specific purpose payments, the wage element of the indexation factor is derived as the ratio of the annual safety net adjustment (SNA) to average weekly ordinary time earnings (AWOTE). Taking last year's SNA of $19 and with AWOTE then at $938 per week, the wage element in the factor was 2.0 per cent. However, for a full time HACC worker, who may earn as little as $600 per week, 2 per cent translates to only $12 per week - - insufficient to even cover the SNA itself.

Accountability

In terms of the Committee's interest in accountability to the community for the quality and delivery of public hospital services, the Victorian Government considers that public hospitals in Victoria are already highly accountable.

- Through their community consultative structures they are accountable to their local communities.
- Through their boards, and through their annual reporting requirements they are accountable to the Victorian Parliament.
- Through the six monthly *Your Hospitals* report, they are accountable to the whole community.
- Through the regular provision of information to the *Australian Institute of Health and Welfare* under the *National Health Information Management Agreement* they provide a wealth of information available to those who seek a detailed understanding of health care provision.
- Through their requirement to maintain accreditation, they are accountable for the maintenance of high quality services.
- Through their internal clinical governance arrangements they are accountable for the reporting and minimization of adverse events and through the *Sentinel Event Program Annual Report* there is accountability to the wider community, and

- Through the Victorian budget process and Auditor-General requirements accountability in relation to system financial performance is maintained.

There is always more information that could be put into the public domain, but assembling information involves direct costs and diversion of scarce resources, and the Committee needs to recognise that in a system of finite resources the provision of such information needs to be subject to appropriate benefit-cost tests.

Moreover, the range of public hospital accountability measures outlined above should be contrasted with the relatively weak accountability measures that apply to private hospitals, and to MBS and PBS services. For example, the *Your Hospitals* report presents extensive information on the timeliness of the provision of hospital services, and the Department of Human Services now publishes detailed information on the internet, updated quarterly, on waiting times for elective surgery in all major hospitals.

Yet for GP services, where the inability to get an appointment quickly can often be a serious concern and lead to unnecessary usage of hospital emergency departments, no waiting time data are published.

Currently, the private hospital/private specialist system does not have anything resembling the sentinel events reporting and accountability systems to which public health services are subject. And some basic information about private medical services, such as a breakdown of Medicare statistics into admitted and non-admitted components, is not publicly revealed. In relation to aged care, despite the key role that all states, particularly Victoria, play in the provision of aged care services, Victoria has only been given access to a very limited range of Commonwealth-held aged care data, and without any certainty of supply.

If state and regional health service planning is to be improved, especially if the focus on prevention, promotion and primary health care is to be strengthened, it is essential that greater efforts are taken to extend the range of health service information held by the Commonwealth that is made available to state and territories. A formal health information sharing agreement between the states and territories and the Commonwealth would be highly desirable.

As well as being needed for planning purposes, health service utilisation data is also a key ingredient in the financial accountability of health service providers to health funding bodies, including governments and insurers. While providers need to be financially accountable, a very detailed approach to output accountability can inhibit their ability to respond flexibly to the needs of their clients. As noted above, improved flexibility was a key reason for the creation of Victoria's SRHS policy, but in some cases Commonwealth-State funding arrangements constrain how much can be done. For example the *Home and Community Care (HACC) Agreements* impose highly detailed planning and accountability requirements on the States – affecting both planning and reporting processes – that can tie up considerable resources for questionable benefit.

Just as over-regulation in the market sector stifles business competitiveness and innovation, so overly detailed accountability rules applied to health service providers can hinder the development of an effective and responsive health system.

The Victorian Government welcomes this inquiry, and looks forward to it, and the health reform work being undertaken for COAG, leading to the development of better health funding arrangements in Australia.

Yours sincerely

Bronwyn Pike MP
Minister for Health