2

Overview

> ….. *what I've described as the dogs breakfast of divided responsibilities which bedevils our health system or our health systems. As many of you who have been in public, private and other health institutions would know, it's possible on a moment by moment, hour by hour basis to shift from federally funded but privately delivered services to federal and state funded but publicly delivered services to federally funded but state delivered services to federally subsidised and also privately funded services.*[1]

2.1 This chapter provides important background to the responsibilities of different levels of government for health care and the structure of health funding and service delivery arrangements. On the whole, health outcomes compare favourably to similar overseas countries. However, rising costs of health care and a funding structure that can create incentives for governments to shift costs to others can compromise the ability of public and private health care providers to offer the care that patients require.

Roles and responsibilities

2.2 The Australian health system is complex. Three levels of government and the private sector have significant roles in raising funds,

1 Hon Tony Abbott MP, Speech to the Centre for Independent Studies policy makers forum, 20 September 2006, viewed on 24 October 2006 at www.cis.org.au/Events/policymakers/tony_lecture/Abbott_lecture_06.pdf.

allocating resources, regulating and delivering health services. In many cases these roles overlap. As a result, decisions by one government (or private sector health provider) can impact on other parties.

2.3 Patients do not always see, or care about this complexity, or which level of government pays for their health care.

2.4 State governments have primary responsibility under current arrangements for health services, including most acute and psychiatric hospital services. At federation, the only explicit Commonwealth power in relation to health was quarantine matters. In 1946, a constitutional amendment allowed the Commonwealth to provide pharmaceutical, sickness and hospital benefits and medical and dental services, without altering the powers of the states in this regard. The constitution also allows the Commonwealth to provide financial assistance to any state on any terms and conditions that the Parliament deems appropriate.[2]

2.5 Consequently, responsibility for parts of the health system is shared between the Commonwealth and state governments. Inquiry participants sometimes viewed this shared responsibility differently, with the Department of Health and Ageing emphasising 'complementary' responsibilities and a 'partnership' between the Commonwealth and state governments.[3]

2.6 The Western Australian Government noted that although there were areas where states have maintained major responsibility, the Commonwealth exercised a substantial degree of 'control' over policy and funding through its use of conditional grants.[4]

2.7 Notwithstanding the sometimes shared role, the Commonwealth has assumed the leading role to provide universal and affordable access to high quality medical, pharmaceutical and hospital services through Medicare and the pharmaceutical benefits scheme. It also has clear responsibility for some population groups using the health system — including funding for residential aged care services and community care and war veterans.[5]

2.8 The Department of Health and Ageing noted that the Commonwealth provides a 'leadership' role in areas of national policy significance,

2 See Section 51 (xxiiiA) and Section 96 of the *Commonwealth of Australia Constitution Act*.

3 Department of Health and Ageing, sub 43, p 6.

4 Western Australian Government, sub 124, p 3.

5 Department of Health and Ageing, sub 43, p 6.

including protecting the overall health and safety of the population, improving access to health services by the Aboriginal and Torres Strait Islander population, guiding national research and evaluation, trialling innovative service delivery approaches and coordinating information management.[6]

2.9 State governments are the main providers of publicly provided health services including:

- public hospital services;
- mental health programs;
- home and community care;
- child, adolescent and family health services;
- women's health programs;
- public health services; and
- inspection, licensing and monitoring of premises, institutions and personnel.[7]

2.10 The Commonwealth has important responsibilities for the development and training of the health workforce through the funding and allocation of university places and medical school facilities and setting criteria for overseas trained medical professionals to work in Australia. State governments partly share the responsibility for development and training through their provision of clinical training places in public hospitals and their funding and regulation of vocational training. The responsibility of different levels of government for workforce training and development is examined in more detail in chapter 4.

2.11 Local government does not have a legislated or constitutional role in the health system.[8] However, many local governments are involved in delivering health services such as immunisation programs and aged care services and providing infrastructure to service providers.[9]

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6 Department of Health and Ageing, sub 43, p 6.

7 Western Australian Government, sub 124, p 3.

8 Local Government Association of NSW and Shires Association of NSW, sub 18, p 5.

9 Western Australian Local Government Association, sub 34, pp 4–5; Local Government Association of NSW and Shires Association of NSW, sub 18, p 5; Australian Local Government Association, sub 36, pp 4–9.

2.12 Local government also has a role in the provision of 'public health-type' services such as water and air pollution abatement, food quality standards enforcement and the provision of recreation and leisure facilities.[10] The role of local governments in delivering health services is examined in more detail in chapter 6.

2.13 There are areas of the health system, such as dental care, where the Commonwealth and state governments do not agree on where the responsibility for funding and delivery lies.[11]

2.14 In the case of dental care, the long waiting lists for public dental services and evidence of declining oral health in the population[12] indicate that disagreements between governments over funding responsibility are leading to poor health outcomes for some Australians.

Funding health care

2.15 Total expenditure on health goods and services in 2004-05 was estimated at $87.3 billion, an average of $4,319 per person. Of this, 94.1 per cent was for recurrent expenditure and 5.9 per cent was for capital formation and capital consumption. Average expenditure per person varies across states, ranging from $4,047 in Tasmania to $4,834 in the Northern Territory.[13]

10 Australian Local Government Association, sub 36, pp 4–9.

11 Australian Dental Association, sub 28, p 9; Western Australian Government, sub 124, p 3; Department of Health and Ageing, sub 43, pp 6–7.

12 Spencer J, 'Narrowing the inequality gap in oral health and dental care in Australia', Australian Health Policy Institute (2004), The University of Sydney, Commissioned paper series, pp 5–8; Australian Dental Association, sub 28, p 18.

13 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), pp 9, 16 and 18.

2.16 Per capita, the cost of the Australian system compares favourably with other developed countries (table 2.1).

Table 2.1 Health expenditure per person, Australia and other selected OECD countries, current prices, 1993 to 2003[(a)] ($)

Year (a)	**Australia**	**Canada**	**France**	**Japan**	**NZ**	**UK**	**USA**	**Avg** (b)
1993	2,052	2,699	2,517	1,829	1,494	1,651	4,498	2,409
1998	2,695	3,009	2,929	2,283	1,898	2,066	5,368	2,886
2003	3,855	4,054	3,919	n.a.	2,546	n.a.	7,607	4,035

Notes: (a) Estimated health expenditure according to the International Classification of Health Accounts excludes expenditure on health research. Expenditures converted to Australian dollar values using GPD purchasing power parities. (b) Average of 27 countries (excluding Japan and UK) weighted by population or GDP.

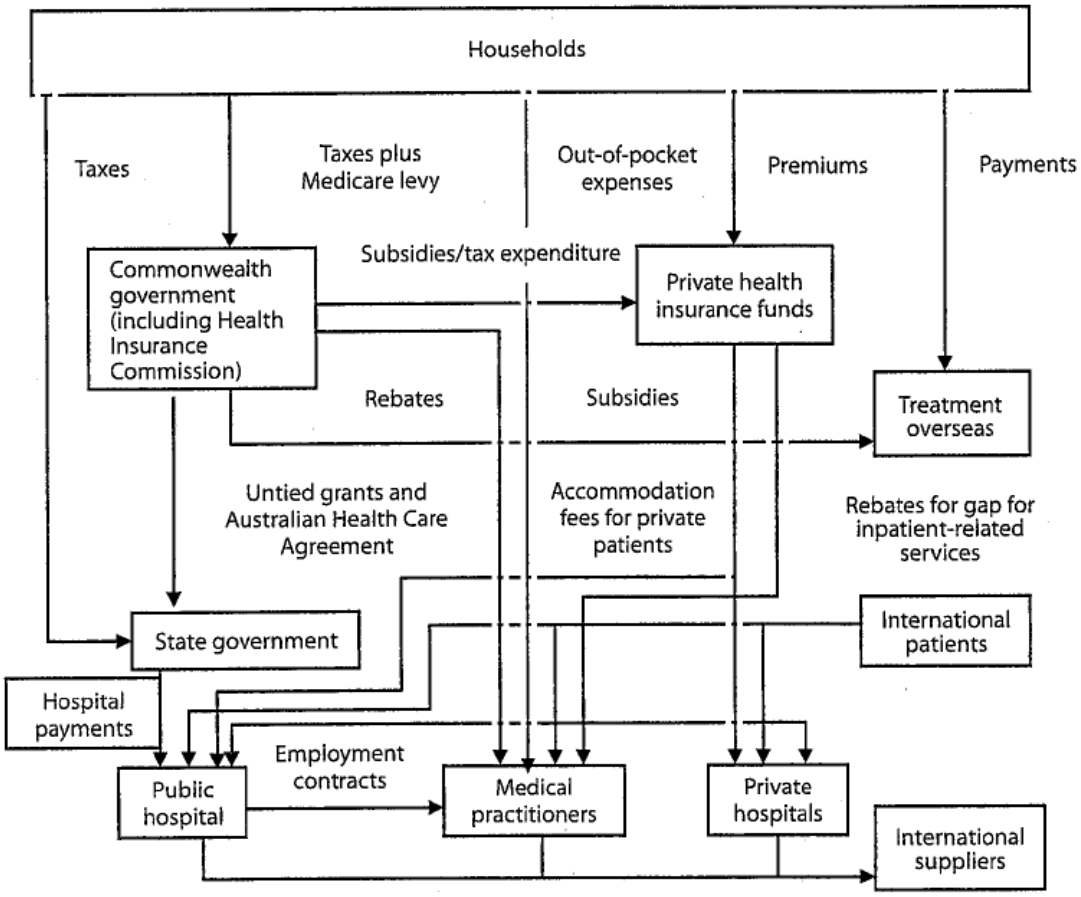
Source Australian Institute of Health and Welfare, Australia's health 2006 (2006), p 299.

2.17 Direct funding of health care is complemented by significant expenditure in other areas, including funding of higher education and training and foregone tax revenue from exemptions provided to health care providers by different levels of government. These indirect health expenditures are discussed in chapter 4.

2.18 Health funding arrangements in Australia involve a complex flow of funds between taxpayers, patients, private health insurance funds, public and private service providers and different levels of government (see figure 2.1).

2.19 There has been a greater emphasis towards consumers of health care contributing to their health care in the form of higher out of pocket expenses (see below).

Figure 2.1 Funding flows for hospital and medical services



Source *Adapted from Duckett S, The Australian Health Care System (2004), p 75.*

2.20 Health spending features significantly in the taxing and spending decisions of governments — accounting for around 15 per cent of total Commonwealth general government revenue and 24 per cent of total state government revenue in 2004-05.[14]

2.21 Commonwealth expenditure on health is largely raised through general taxation. Of the Commonwealth's $35.7 billion in health expenditure in 2004-05, around $6.1 billion (17.1 per cent) was raised from the Medicare levy and surcharge.[15] Despite perceptions that revenue raised by the Medicare levy and surcharge is automatically allocated (hypothecated) to support the health system, all money raised by the levy and surcharge is paid into consolidated revenue. In

14 Australian Bureau of Statistics, *Government Finance Statistics, 2004-05* (2006), Cat No 5512.0, pp 10 and 40.

15 Parliamentary Library, Bills Digest, 'Tax Laws Amendment (Medicare Levy and Medicare Levy Surcharge) Bill 2006', p 2; Australian Institute of Health and Welfare, *Health expenditure Australia 2003-04* (2005), p 18.

2003-04, the levy and surcharge accounted for around 3.2 per cent of total Commonwealth taxation revenue.[16]

2.22 The Commonwealth makes a significant contribution to state government health expenditure through specific purpose grant payments that are tied to the delivery of health services. In 2005-06, the Commonwealth provided $9.2 billion to the states in specific purpose grants, with the majority (90.3 per cent) relating to payments under the Australian Health Care Agreements.[17]

2.23 The specific purpose payments from the Commonwealth typically comprise around 30 per cent of state government health-related expenditure.[18] Most of the remaining expenditure is financed through state general taxation revenues, including their share of goods and services tax collections, which totalled $36.8 billion in 2005-06.[19]

2.24 There are some instances where specific state government taxes, such as those on gambling revenue or tobacco taxes, are hypothecated for health-related purposes.[20] For example, in Victoria, tax revenue from gaming machines raised of around $1 billion is transferred to a trust fund that contributes approximately one-eighth of the Victorian Government's health-related expenditure in 2005-06.[21]

2.25 In total, the Australian and state governments make a significant contribution to health expenditure, accounting for 45.6 per cent and 22.6 per cent of health expenditure respectively in 2004-05.[22]

2.26 Non-government sources also make an important contribution to health funding, accounting for around $27.7 billion (32 per cent) of overall health expenditure in 2004-05.[23]Around $18.5 billion

16 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 434.

17 The Treasury, *Federal Financial Relations 2006-07*, Budget Paper No. 3 (2006), pp 47–48.

18 The Treasury, *Final Budget Outcome 2003-04* (2004), p 59; Australian Bureau of Statistics, *Government Finance Statistics Australia 2004-05* (2006), Cat No. 5512.0, p 40.

19 The Treasury, *Federal Financial Relations 2006-07*, Budget Paper No. 3 (2006), p 5.

20 For a summary of gambling-relates taxes that are used for health-related purposes, see Department of Health and Aged Care, *Gambling: is it a health hazard?* (1999), Occasional Papers, New Series No. 2, April; Moodie A, Victorian Health Promotion Foundation (VicHealth), transcript, 28 June 2005, p 49.

21 Victorian Department of Treasury and Finance, *Statement of Finances 2006-07*, Budget Paper No. 4 (2006), p 174; Victorian Department of Human Services, Victorian Budget 2006-07 Information Kit, 30 May 2006, viewed on 15 August 2006 at www.dhs.vic.gov.au/budget/downloads/budget_07.pdf.

22 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 23.

23 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 23.

(59.7 per cent) of non-government funding for health goods and services is from out-of-pocket payments by individuals, who either meet the full cost of a service or good or share funding with third-party payers—for example, private health insurance funds or the Commonwealth through income tax offsets. The remaining share of non-government sources are contributed by individuals via private health insurance funds (20.5 per cent) and other sources such as workers' compensation schemes.[24]

Funding and expenditure trends

2.27 Total health expenditure in 2004-05 increased by $8.2 billion over the previous year. This is an increase of 10.3 per cent, or 5.9 per cent after allowing for inflation. Over the period 1994-95 to 2004-05, the average annual growth was 8.3 per cent, or 5.3 per cent after allowing for inflation.[25]

2.28 The proportion of total health expenditure sourced from the Commonwealth government, state and local governments, and the non-government sector has been fairly stable since 1998-99, at around 46 per cent, 23 per cent and 31 percent respectively.[26]

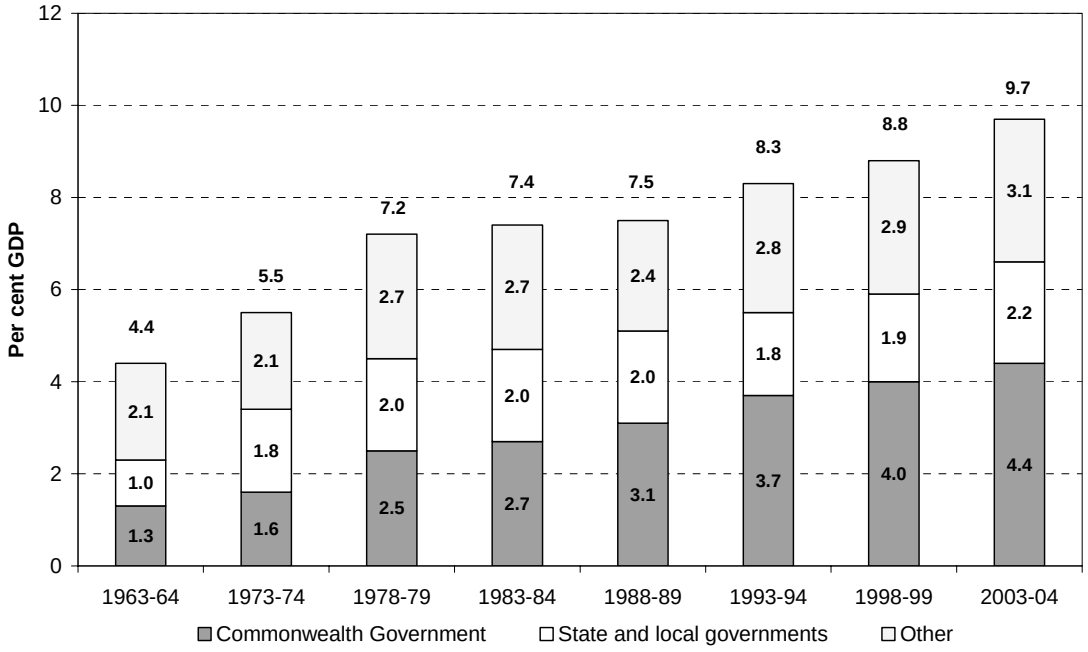
2.29 While some sources of health funding are rising more rapidly than others, over the longer term the Commonwealth and state governments and the non-government sector have all contributed to the overall increase in health expenditure relative to the growth in the economy over the past 40 years (figure 2.2).

24 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 38.

25 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 9.

26 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 23.

Figure 2.2 Total health expenditure and GDP, current prices, by source of funds, 1963-64 to 2003-04



Note *Other includes individual out-of-pocket, PHI and other non-government (eg: workers' compensation)*

Source *Australian Institute of Health and Welfare, Health expenditure database, viewed on 20 September 2006 at www.aihw.gov.au/expenditure/datacubes/index.cfm.*

2.30 The increase in state government expenditure has not been uniform, with some jurisdictions increasing their contribution to health funding for some types of health services at a faster rate than others. In the case of public hospital funding, the increase in average annual health expenditure per person over the six years to 2004-05 by the states ranged from 3.6 per cent in Tasmania to 8.3 per cent in the Northern Territory (figure 2.3).[27]

27 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 291.

Figure 2.3 State and territory government recurrent expenditure per person, weighted Australian population, 2004-05 and 1998-99

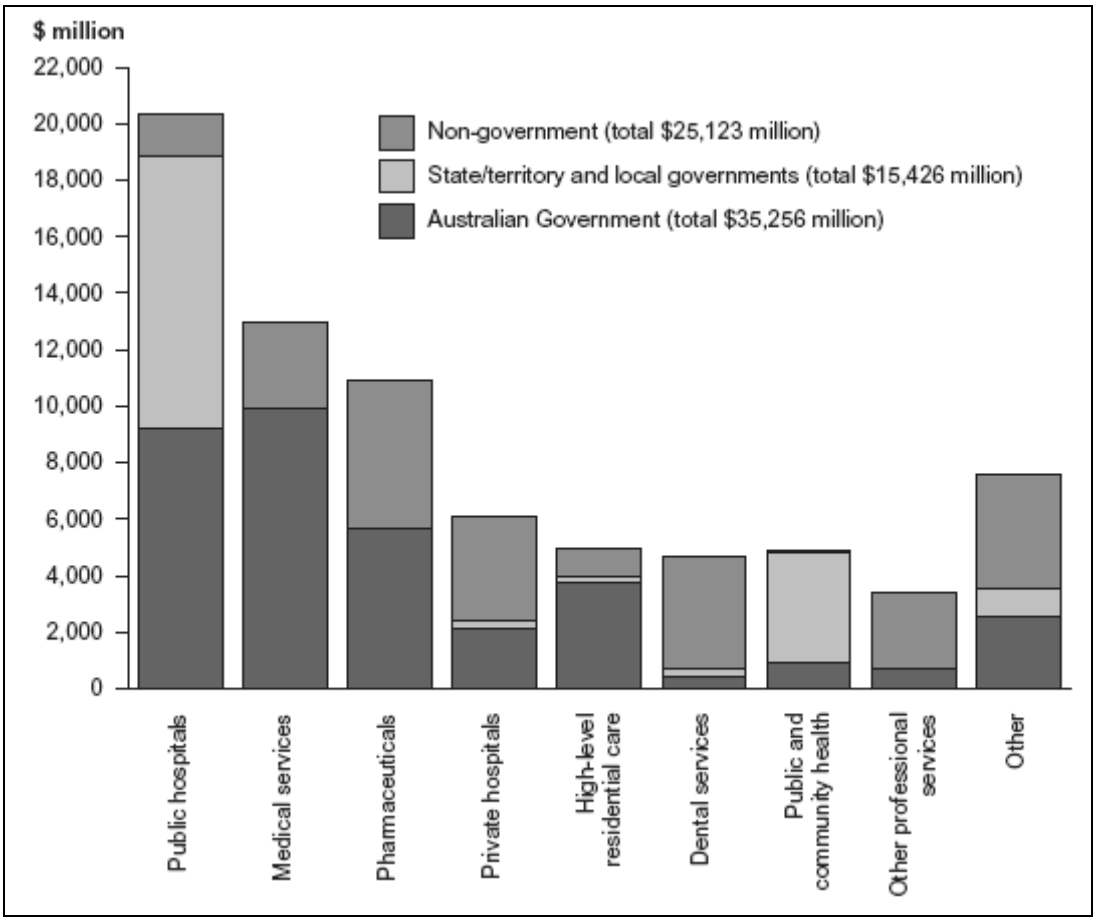
Rank		2004–05 ($)	1998–99 ($)	Rank
1	Northern Territory	1355	774	1
2	Australian Capital Territory	862	569	2
3	Western Australia	826	527	4
4	Tasmania	696	543	3
5	New South Wales	615	427	5
6	Victoria	555	328	7
7	South Australia	554	353	6
8	Queensland	479	319	8
	Total	600	393	

Source *Department of Health and Ageing, The state of our public hospitals, June 2006 Report (2006), p 13.*

2.31 The relative importance of the funder for different health services varies according to the type of health service (see figure 2.4). In general terms:

- funding for public hospital services is shared by the Commonwealth and state governments;
- private hospital services are largely funded from non-government sources, although the Commonwealth subsidises in-hospital medical costs through the Medicare Benefits Schedule (MBS) and through private health insurance rebates;
- the Commonwealth is the most important source of funds for high-level residential aged care, medical services and health research;
- state governments provide most of the funding for community health programs and public health services; and
- funding for pharmaceuticals is shared between the Commonwealth and non-government sources, and the states in relation to public inpatient services.

Figure 2.4 Recurrent health expenditure by health area and source of funds, current prices, 2003-04



Source *Australian Institute of Health and Welfare, Australia's health 2006 (2006), p 302.*

2.32 The major agreements and funding arrangements that determine sources of funding for different health services are described in box 2.1. It is important to note that where an episode of care involves patients moving between different areas of health care — such as from a public hospital to a community care setting or residential aged care — the relative contribution to care by governments and individuals can also change.

Box 2.1 Key health system funding arrangements and programs

Medicare benefits schedule (MBS) — a 'list' of medical services and selected optometry and dental services specifying the level of benefits paid for private medical services by the Commonwealth. Annual expenditure on the MBS is uncapped and depends on the number of services provided. In 2004-05, MBS expenditure was around $9.9 billion for more than 236 million services — an average of 11.6 services per resident at an average cost of $487.69.[28]

Pharmaceutical benefits scheme (PBS) — provides for the supply of listed pharmaceutical products to eligible people at subsidised rates. Annual expenditure on the PBS is uncapped, and depends on depending on the quantity of different pharmaceutical products dispensed to patients. In 2004-05 expenditure on the PBS was around $5.5 billion for 170 million services — an average of 8.33 services per resident at an average cost of $268.30 per resident. A similar Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidies to entitled veterans.[29] In 2004-05, RPBS expenditure was around $274 million for 15.7 million services.[30]

Australian Health Care Agreements (AHCAs) — commit the Commonwealth to formula based grants to the states as a contribution to the cost of provision of public hospital services. In return, the states are required to provide equitable access to services, free of charge (with limited exceptions) based on clinical need and within a clinically appropriate period. Over the five years of the current agreement (2003–2008), state governments will receive an estimated $42 billion from the Commonwealth, with $7.95 billion provided in 2004-05.[31] The 2003–2008 Agreements require each state to increase funding for public hospitals to at least match the rate of growth of Commonwealth funding over the same period.

Private health insurance rebate — individuals taking out eligible private health insurance policies are entitled to a reimbursement or discount of 30 per cent (or 35 per cent for those aged 65-69 years and 40 per cent for people aged 70 years and over) on the cost of private health insurance. In 2003-04, the cost of the rebate was around $2.5 billion.[32]

Public Health Outcomes Funding Agreement — Agreements between the Commonwealth and state governments to provide funding for a range of public health programs. Expenditure

28 Medicare Australia, Annual Report 2004-05 Statistical Tables, Medicare statistical tables, 3, 4, 13 and 14, viewed on 15 July 2006 at www.medicareaustralia.gov.au/about/about_us/annual_report/04-05/statistics.htm.

29 References to the PBS in this report can generally be taken to include the RPBS.

30 Medicare Australia, Annual Report 2004-05 Statistical Tables, Pharmaceutical and Repatriation Pharmaceutical Benefits Scheme statistical tables 1, 2, 4, 5, 13 and 14, viewed on 16 October 2006 at www.medicareaustralia.gov.au/about/about_us/annual_report/04_05/statistics.htm.

31 Department of Health and Ageing, *The State of our public hospitals, June 2006 report* (2006), p 12.

32 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 310.

by the Commonwealth over the five-year agreements covering the period 2004-05 to 2008-09 is $812 million (adjusted annually for indexation).[33]

Residential aged care — the Commonwealth has primary responsibility for the funding of residential aged care places. In 2003-04, the Commonwealth spent $5.2 billion on residential aged care (including contributions to veterans).[34]

Veterans' health services — eligible veterans, war widows and widowers are entitled to health services funded by the Department of Veterans Affairs. Expenditure by the department in 2004-05 was around $4.1 billion, or an average of $12,400 per eligible person.[35]

2.33 The Commonwealth has also entered into arrangements with peak industry groups to manage selected areas of expenditures within its MBS and PBS programs. These include co-operative strategies which promote affordability of services for patients, including pharmaceuticals, diagnostic imaging and pathology services (box 2.2). The agreements for radiology and pathology include provisions that allow for expenditure adjustments for demonstrable and measurable instances of cost shifting between the public and private sectors.[36]

33 Department of Health and Ageing, Public Health Outcome Funding Agreements (PHOFAs), viewed on 27 July 2006 at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-about-phofa-phofa.htm.

34 Department of Health and Ageing, Australian Health and Ageing System - The Concise Factbook - April 2006, viewed on 30 June 2006 at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-statistics-april2006-table5.

35 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 293.

36 Department of Health and Ageing, *Radiology Quality and Outlays Memorandum of Understanding (MOU) between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association 1 July 2003 to 30 June 2008* (2003), clause 5.8; Department of Health and Ageing, *Radiology Quality and Outlays Memorandum of Understanding (MOU) between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association 1 July 2003 to 30 June 2008* (2003), clause 5.7.

Box 2.2 Selected expenditure management arrangements

Pathology Quality and Outlays Memorandum of Understanding (MOU) — an agreement between the Commonwealth, the Australian Association of Pathology Practices, the Royal College of Pathologists and the National Coalition of Public Pathology to promote access to quality, affordable pathology services and manage government outlays relating to MBS pathology services. The current MOU covers the period 2004-05 to 2008-09 and applies to more than $8 billion of pathology services.[37]

Radiology Quality and Outlays MOU — an agreement between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association to promote access to quality, affordable radiology services. The current MOU covers the period 2003-04 to 2007-08 and applies to more than $5.7 billion of radiology services.[38]

Fourth Community Pharmacy Agreement — an agreement between the Commonwealth and the Pharmacy Guild of Australia that sets out the remuneration pharmacists will receive for dispensing PBS medicines. The agreement covers the period 1 December 2005 and to 30 June 2010 and provides for $11.1 billion in payments for the dispensing and supply of PBS medicines.[39]

The rising cost of health care

2.34 All levels of governments are concerned about the rising costs of health care, which is projected to consume a significant and increasing proportion of the economy's future resources. A number of factors contribute to rising prices for health services and the growth in demand for health services.[40]

37 Department of Health and Ageing, *Pathology Quality and Outlays Memorandum of Understanding between the Australian Government and the Australian Association of Pathology Practices and the Royal College of Pathologists and the National Coalition of Public Pathology, 1 July 2004 to 30 June 2009* (2004).

38 Department of Health and Ageing, *Radiology Quality and Outlays Memorandum of Understanding (MOU) between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association 1 July 2003 to 30 June 2008* (2003).

39 Department of Health and Ageing, *The Fourth Community Pharmacy Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia* (2005).

40 Australian Health Services Alliance, sub 5, p 2; Australian Health Insurance Association, sub 16, pp 16–19; ACT Government, sub 65 p 3; Macquarie Health Corporation, sub 55, p 5; Local Government Association of NSW and Shires Association of NSW, sub 18, p 4; Caboolture Shire Council (Qld), sub 103, p 3.

2.35 The committee noted a range of recent projections of future health costs in Australia, most of which forecast a doubling of government expenditure on health as a proportion of GDP over the next 40 years.[41]

2.36 It is important that governments continue to take action to address the drivers of rising demand on the health system as well as make changes that can improve health system efficiency. Such action should not be delayed and should be seen a long term investment. In many cases, such as preventing chronic conditions and supporting more flexible use of the health workforce, costs may actually increase in the short term but targeted investments must be made to secure a sustainable health system in the long term.

2.37 The Australian Institute of Health and Welfare reported that 'excess health inflation', the difference between the rate of change in the price of health services and the general inflation rate, has averaged 0.8 per cent over the 10 years to 2003-04.[42]

2.38 Some of the explanations for the cost pressures experienced in the health system provided to the committee included:

- technology — newer methods of treatment, including pharmaceuticals, are more expensive than previous treatments. As these more expensive technologies are introduced, the cost of care rises;[43]
- increasing utilisation —higher expectations about what medical care can achieve, rising incomes and the greater availability of new treatment technologies have increased the community's demand for health services;[44] and
- workforce shortages — changes in the gender composition of the health workforce, a lack of skilled professionals, competition

41 The Treasury, *Intergenerational Report 2002-03*, Budget Paper No. 5 (2002), p. 39; Productivity Commission, Economic implications of an ageing Australia (2005), p 169; OECD, 'Projecting OECD health and long-term care expenditures: What are the main drivers?' (2006), Economics Department Working Papers No. 477, p 31; Office of Financial Management, *NSW Long-Term Fiscal Pressures Report 2006-07*, Budget Paper No. 6 (2006), p 4-2; Western Australian Government, sub 124, p 2.

42 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 289.

43 Health Insurance Restricted Membership Association of Australia, sub 6, p 3; Australian Health Insurance Association, sub 16, p 32; MBF Australia Limited, sub 19, p 18; Medical Industry Association of Australia, sub 61, p 9; Australian Health Care Association, sub 62, p 7.

44 Australian Private Hospitals Association, sub 24, p 3; Harrison B, Australian Health Services Alliance, transcript, 23 August 2005, p 3.

between the public and private sectors and a reduction in the hours worked by medical staff as the workforce ages have allowed practitioners to reduce the hours they work without significantly affecting their income.[45]

2.39 In addition to increases in the price of health services, the quantity of health services delivered in many parts of the health system has increased significantly in recent years. Areas that had experienced increases in demand include public and private hospital admissions, the use of Medicare funded medical services and pharmaceutical prescriptions (table 2.2). Several submissions also pointed to increased pressures at public hospital emergency departments.[46]

Table 2.2 Use of selected medical and pharmaceutical services, 1996-97 to 2003-04

Service	1996-97	2003-04	Change (per cent)
Public hospital separations (per 1,000 population)	195.8	207.7	6.1
Private hospital separations (per 1,000 population)	108.4	130.9	20.8
Medicare services (per 1,000 population)	1,063	1,087	2.3
Pharmaceutical benefits scheme prescriptions (per capita)	6.7	8.2	22.4

Source *Medicare Australia, Statistics, viewed on 25 August 2006 at www.medicareaustralia.gov.au/about/media/statistics.htm; Australian Institute of Health and Welfare, Australia's health 2006 (2006), p 362, Australia's health 2002 (2002), p 282; Department of Health and Ageing, correspondence received 5 September 2006.*

2.40 Although rising health costs are a concern to governments, inquiry participants also pointed to the economic and social benefits of higher health expenditures.[47] The Medical Industry Association of Australia noted:

> In the broadest sense, medical technology has been responsible for significant reductions in mortality, morbidity (including disability) and improvements in quality of life in all age groups. In particular, many medical devices have

45 Australian Health Insurance Association, sub 16, p 10; Fisher L, Private Hospitals Association of Queensland, transcript, 7 April 2006, p 68; Warden R, NT Department of Health and Community Services, transcript, 23 August 2006, p 6.

46 City of Darebin (Vic), sub 32, p 2; ACT Government, sub 64, p 5; Western Australian Government, sub 124, p 8.

47 Australian Association of Pathology Practices, sub 38, p 5; Medicines Australia, sub 42, p 4.

> reduced the use of some drugs, reduced hospital admissions and length of stay and allowed individuals to function normally. As a result, this has reduced the indirect costs for care of patients and the healthcare system.[48]

2.41 It is important that health funding arrangements do not restrict unnecessarily the introduction of new technologies and procedures that provide significant benefits to patients or the economy.

2.42 While governments are generally more exposed to rising health care costs than individuals, the committee also noted concerns from several inquiry participants of the rising costs of health care, which were usually experienced in the form of higher co-payments, out-of-pocket costs and rising private health insurance premiums.[49] An individual told the committee that:

> I am getting to the stage now, because of the income that I get from my allocated pension plus my Centrelink pension, where I do not know whether I am going to be able to afford to be in a private health fund for much longer. The only reason I am staying in it for as long as I can is in case I get sick again.[50]

Cost shifting

2.43 Cost shifting occurs when service delivery is arranged so that responsibility for services can be transferred to another program funded by another party, without the agreement of the other party.[51]

2.44 The complexity of funding and delivery arrangements and the division of responsibilities between the Commonwealth and state governments provides opportunities and incentives for the costs of health care to be shifted from one level of government to another, including local government.[52] Issues of cost shifting are also raised when governments shift the cost of treatments to patients for services

48 Medical Industry Association of Australia, sub 61, p 5.

49 Professor Stephen Leeder, sub 3, p 3; Australian Dental Association, sub 28, p 2; ACT Government, sub 64, p 3; Health Group Strategies, sub 116, p 11; Catholic Health Australia, sub 35, p 27.

50 Brown D, transcript, 20 July 2006, p 41.

51 Ross, B et al, *Health financing in Australia: the objectives and players* (1999), Occasional Papers: Health financing series volume 1, Department of Health and Aged Care, p 37.

52 Western Australian Government, sub 124, p 7.

that have previously attracted no charge or increase the level of patient co-payments.[53]

2.45 In an environment of rapidly rising health costs, there may be significant incentives for health providers to engage in activities that shift the costs of health care to another party.

2.46 Cost shifting can occur at the boundaries of different parts of the health system, such as between general practice and hospitals, general practice and aged care and aged care and hospitals.[54]

2.47 There can also be claims of cost shifting at a broader level, with state governments arguing that the Commonwealth Government's removal of incentives for GPs to bulk bill patients after hours leading to an increase in the pressure of GP-type patients presenting at public hospital emergency departments.[55]

2.48 Many local governments also noted that the issue of cost shifting was also relevant to them.[56]The City of West Torrens told the committee that costs were sometimes shifted to local governments over time when grant funding for a specific program expired:

> While funding may be provided by state or federal governments for project based initiatives, it is often only seed funding whose subsequent termination places considerable pressure on our ability to provide long-term comprehensive programs.[57]

2.49 While 'cost shifting' is almost always used as a pejorative term, it is not necessarily a symptom of inappropriate behaviour. A distinction should be made between situations where the transfer of costs from one party to another is the purpose of the change in service delivery arrangements, or is a consequence of changes in clinical practice. The substitution of a new drug therapy for surgery, for example, shifts costs from the states to the Commonwealth but should reduce overall costs and/or improve outcomes.

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53 Medicines Australia, sub 42, p 11; Government of Victoria, sub 67, p 6.

54 Royal Australian College of General Practitioners, sub 19, p 3; Catholic Health Australia, sub 35, p 9.

55 Western Australian Government, sub 124, p 8; ACT Government, sub 64, p 3; Victorian Government, sub 67, p 3.

56 Dubbo City Council (NSW), sub 4, p 1; Bankstown City Council (NSW), sub 13, pp 2–3; Local Government Association of NSW and Shires Association of NSW, sub 18, p 11.; Western Australian Local Government Association, sub 34, p 8.; City of Mandurah (WA), sub 46, p 3.

57 Trainer J, City of West Torrens (SA), transcript, 2 May 2006, p 35.

2.50 Opportunities for cost shifting also dilute government accountability for health outcomes. The chair of the committee noted that blame shifting did not offer a solution to some members of the community:

> I quote the example of Mrs Smith who comes to me because she needs a hip replacement and has to wait five years and she is 80. I write to [the Minister for Health], and he writes back to me and says: 'Look, it's a state matter. I can't help her.' Then I write to the state minister, and he writes back and says, 'The Commonwealth doesn't give us enough money.' She gets two letters from the health ministers, but she does not get her hip replacement. This is ridiculous.[58]

2.51 Cost shifting is examined in more detail in chapter 3.

Private health

2.52 The delivery of health services outside public hospitals is dominated by fee-for-service arrangements with private health providers such as general practitioners, allied health professionals, pathologists, dentists and pharmacists.

2.53 The public and private health systems are increasingly interdependent — sometimes sharing the same workforce and facilities. Often the delivery of quality health care over a patient's episode of care requires coordination between public and private health providers working in laboratories, hospitals and general practitioner and allied health professional clinics.

2.54 Health funding arrangements need to reflect this interdependence and facilitate the cooperation and coordination required to achieve seamless delivery of health care across the continuum of care.

2.55 For this inquiry, the committee has concentrated on the part of the private health sector comprising the private health insurance industry and private hospitals. In 2004-05, there were almost 2.8 million separations in private hospitals, with total revenue of more than $6.6 billion.[59] In the same period private health insurance funds insured more than 8.8 million people, collecting more than $8.6 billion

58 Hon Alex Somlyay MP, transcript, 29 March 2006, pp 2–3.

59 A separation is the formal process by which a hospital records the completion of a treatment and/or care for an admitted patient (Australian Bureau of Statistics, *Private Hospitals Australia* (2006), Cat No. 4390.0, p 9).

in premiums and paying more than $7.6 billion in benefits to members.[60]

2.56 Health funds operate in an environment where products, prices, registration and the financial and prudential aspects are regulated.[61] Key government agencies involved in private health insurance regulation include:

- Department of Health and Ageing — assessing annual premium increases requested by funds;
- Private Health Insurance Administration Council — regulating the financial and prudential aspects of the industry, disseminating financial and statistical data and information to inform consumer choice; and
- Private Health Insurance Industry Ombudsman — resolving complaints about private health insurance and an umpire in dispute resolution at all levels within the private health insurance industry.

2.57 Contracting between health insurance funds and private hospitals underpins the delivery of health services to privately insured patients in private hospitals. Private hospitals and private day hospital facilities receive hospital benefits from health funds through either a hospital purchaser provider agreement (contract) that they have negotiated with the fund or, where a contract does not exist, the Commonwealth determined default benefit. Health funds are required to cover all eligible members that receive hospital treatment even where the fund does not have a contract with the hospital.[62]

2.58 Contracting arrangements between health funds and private hospitals are a commercial matter for the parties. The Australian Private Hospitals Association highlighted the often fractious nature of these negotiations and the sometimes adverse impact on patients when contracts ceased.[63]

2.59 The committee has examined private hospitals and private health insurance arrangements in more detail in chapter 8.

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60 Department of Health and Ageing, sub 43, p 23.

61 Department of Health and Ageing, sub 43, p 22.

62 Department of Health and Ageing, sub 43, p 30.

63 Gee C, Australian Private Hospitals Association, transcript, 21 September 2005, p 47; Roff M, Australian Private Hospitals Association, transcript, 23 August 2005, p 15; Toemoe G, Australian Private Hospitals Association, transcript 24 August 2005, p 3.

Health system outcomes

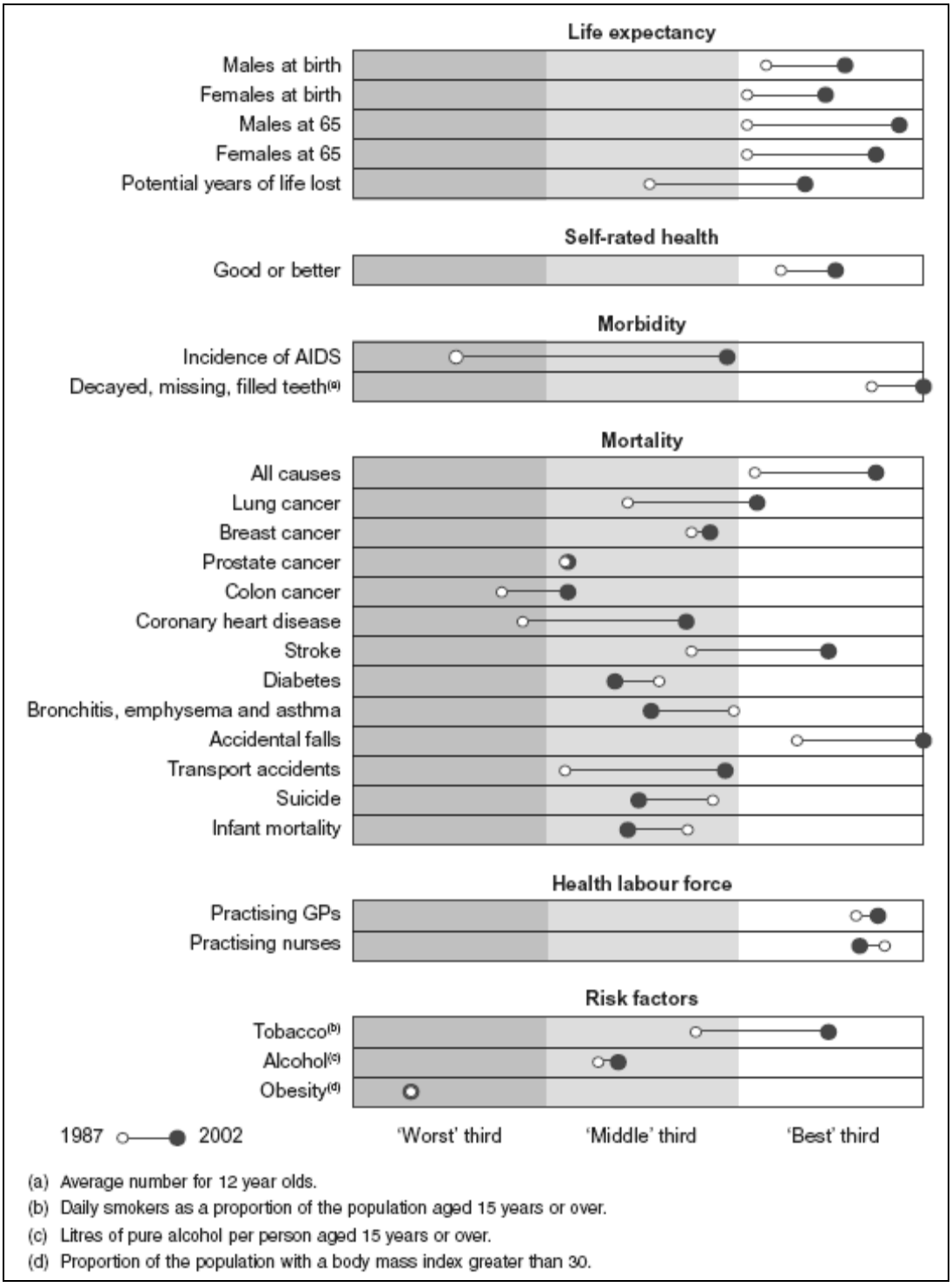
2.60 The Australian health system, or parts of it, was amongst the best in the world. Objective measures of health outcomes demonstrate that overall, the standard of health care in Australia is generally better than most developed countries (figure 2.5).

2.61 The Australian health system also performs relatively well in terms of access to services and the quality of care:

- relative to Canada, the UK and the US, a higher proportion of Australians see a doctor promptly when they need to, and rate their care as very good or excellent;
- waiting times for emergency departments are shorter than for the US, Canada and the UK; and
- waiting times for elective surgery are shorter than for Canada, NZ and the UK.[64]

64 Podger A, *Directions for Health Reform in Australia, Presentation to Productivity Commission Roundtable on Productive Reform in a Federal System* (2005), exhibit 26, p 3.

Figure 2.5 Selected health indicators, Australia's ranking among OECD countries, 1987 and 2002



Source *Australian Institute of Health and Welfare, Australia's health 2006 (2006), p 3.*

2.62 Despite these successes, inquiry participants nominated a number of areas where health performance can be improved including:

- Indigenous health — life expectancy is around 17 years lower than for other Australians, this gap being bigger than the gap between Indigenous and non-Indigenous peoples in the US, Canada or NZ.[65] In the Northern Territory, health status of Indigenous people equates to that of non-Aboriginal Territorians who are twenty years older than indigenous people — both in terms of the extent of disease and outcomes;[66]
- rural and remote health — people in rural and remote areas have worse health status overall than people in the major cities and face higher risk factors such as higher rates of smoking.[67] Standardised mortality data show death rates in Australia increasing with rurality: Australians living in regional, rural and remote areas are 10 per cent more likely to die of all causes than those in major cities, and 50 per cent more likely to do so if they live in very remote areas;[68]
- quality of care in hospitals — the rate of adverse events in hospitals increased from 5.1 per cent of admissions in 2001-02 to 5.5 per cent in 2002-03.[69] A recent study also found that up to 16 per cent of hospitalised patients would suffer an adverse event, 50 per cent of which were preventable and 10 per cent of which would result in permanent disability or death;[70]
- waiting lists for elective surgery — there has been deterioration in recent years in the proportion of patients waiting longer than is clinically appropriate for elective surgery in all states. Median waiting times for selected elective surgery procedures have also increased in most states;[71]
- workforce shortages — shortages were identified in a number of health workforce areas, including general practice,[72] nursing,[73] allied health professionals,[74] dentists[75] and pathologists;[76]

65 Podger A, *Directions for Health Reform in Australia, Presentation to Productivity Commission Roundtable on Productive Reform in a Federal System* (2005), exhibit 26, p 3.

66 Northern Territory Government, sub 60, p 4.

67 National Rural Health Alliance, sub 59, p 19.

68 Rural Doctors Association of Australia, sub 31, p 6.

69 Health Group Strategies, sub 116, p 17.

70 Australian Health Insurance Association, sub 16, p 15.

71 Department of Health and Ageing, *The state of our public hospitals, June 2006 report* (2006), pp 27–29.

72 Australian Divisions of General Practice, sub 15, p 3; Australian Medical Association, sub 31, p 16; Rural Doctors Association, sub 31, p 16; Redcliffe-Bribie-Caboolture Division of General Practice (Qld), sub 81, p 5.

- chronic disease management — Australia has a high rate of potentially avoidable hospitalisations for chronic conditions. Increases in the incidence of chronic diseases suggest that there is an underinvestment in preventative health strategies.[77] Recent research by the Australian Institute of Health and Welfare indicated that the burden of chronic disease falls unevenly across the community, with areas of socio economic disadvantage reporting higher mortality rates and hospitalisation rates than less disadvantaged areas;[78] and
- lifestyle diseases and children's health — rising levels of childhood obesity are expected to lead to an increase in the number of young people diagnosed with type 2 diabetes.[79]

2.63 Several inquiry participants also noted that current funding arrangements can work against providing the continuity of care for people with complex conditions[80] — a situation that is likely to increase as the population ages.[81]The Australian Private Hospitals Association noted that:

> [The patient] might see a specialist in private practice in one specialty, Commonwealth funded through Medicare, and then be referred to another specialist in their rooms, Commonwealth funded through Medicare—probably co-payments in both cases. They might need a hospital admission for a surgery—public and private options. Radiotherapy is a doctor's office service or it might be undergone at a public hospital. In addition—and the cancer patient is a particularly good example—the patient has to

73 Australian Nursing Federation, sub 39, p 4.

74 Australian Healthcare Association, sub 62, p 5

75 Australian Dental Association, sub 28, p 26.

76 Graves D, Royal Australian College of Pathologists, transcript, 5 July 2005, p 2.

77 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, pp 4–5.

78 Australian Institute of Health and Welfare, *Socioeconomic inequalities in cardiovascular disease in Australia: Current picture and trends since 1992* (2006), p 1.

79 Taplin C, M Craig, M Silink and N Howard, 'The rising incidence of childhood type 1 diabetes in New South Wales, 1990–2002', *Medical Journal of Australia* (2005), Vol 183, no 5, pp 243–246; Australian Institute of Health and Welfare, *Australia's young people 2003* (2003), p 167.

80 Royal Australian College of General Practitioners, sub 66, p 8; ACT Government, sub 64, p 2; MBF Australia Limited, sub 29, p 24; Australian Health Insurance Association, sub 16, p 1; Australian Association of Gerontology, sub 53, p 4.

81 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 4.

> make a number of choices about what combination of care they are going to subject themselves to.
>
> The system is now not well geared to putting a comprehensive service around that patient as they move between not just public and private but Commonwealth and state funded health care.[82]

2.64 Areas requiring improvement are examined in further detail in subsequent chapters.

2.65 The committee considers that while pragmatic and largely incremental changes to health funding arrangements can partly address some of these health concerns in the short term, more fundamental changes to health funding arrangements are required to achieve sustainable improvements in health outcomes.

82 Greenman R, Australian Private Hospitals Association, transcript, 24 August 2005, p 9.