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" ... a government big enough to give you everything you want is a government big enough to take from you everything you have."
Former US President, Gerald R. Ford

"For the government, however, the high levels of debt among some baby boomers heading for retirement is a concern and there is an urgent need to increase household saving as we face the fiscal challenges associated with populating ageing"
Treasury, 2002, Budget Paper No 5, Intergenerational Report 2002-03, May

"It is not too difficult to work out why the Federal Government wants to pull its health spending into line. It is rather more difficult to work out how current policy settings can deliver such an outcome"
Roger Kilham: Health and the 2005-06 Federal Budget – A Report by Access Economics Pty Limited For The Australian Medical Association)

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SITUATION

1. The Australian Doctors' Fund accepts the analysis of Roger Kilham of Access Economics as of May 2005 concerning the future direction of Commonwealth Health Spending.

   "In recent years, ***health expenses have grown on average at 8.1% p.a.*** *while total expenses have grown on average by 5.7%. If we project these growth rates forward we can see that* ***health spending would account for half of Federal Budget outlays by the year 2050-51.***

   This is a 'dead brain' projection. As Ginger Meggs might say, it is 'dead set' that Australian voters would baulk at such an outcome. It is not too difficult to work out why the ***Federal Government wants to pull its health spending into line.*** *It is rather more* ***difficult to work out how current policy settings can deliver such an outcome."***
   (Ref: Health and the 2005-06 Federal Budget – A Report by Access Economics Pty Limited for The Australian Medical Association)

2. The Australian Doctors' Fund accepts that there is a credible **debate over what is an adequate level of household savings in Australia** and the nexus between household savings and long term national economic prosperity. The situation was explained by John Quiggin[1] in the Financial Review of the 18 November 2004:

   *" **Australia** is in the **almost unparalleled situation of having negative household savings**....."**Australia is**, in important respects, **in a stronger position than the US.** Australian governments are generally running small surpluses, and the **government balance sheet is strong**, with substantial positive net worth for the government sector as a whole. Since our **negative net savings is due primarily to borrowing against increased values**, a soft landing for the housing sector would presumably imply a gradual increase in saving....."; "however, it's **easy for markets to change their views** of an entire group of countries in a very short time....."; "**Australia is not well-prepared for such a shock**"*

   Whilst the debate over savings and its effect will continue, there appears to be a consensus in public policy circles with the view expressed in by Treasury in its **Intergenerational Report 2002-03:**

   "For the government, however, the ***high levels of debt among some baby boomers*** *heading for retirement is a concern and there is* ***an urgent need to increase household saving as we face the fiscal challenges associated with populating ageing"***[2]

CONCLUSION

1. **Federal Government spending on health cannot continue to increase at its current rate.**
2. **Savings for future health care expenditure must be encouraged and rewarded.**

[1] An Australian Research Council Federation Fellow in Economics and Political Science at the University of Queensland.
[2] Treasury, 2002, Budget Paper No 5, Intergenerational Report 2002-03, May

HEALTH FINANCING IMPERATIVES

To establish a means whereby Australians are **encouraged to accept greater personal responsibility for their future health care costs** where possible, whilst making **provision for those who have no means of saving and/or who suffer from chronic illness** and need community support.

To **free Australian public hospitals from the constraints** placed upon their ability to care for patients because of government ownership and accompanying bureaucratic control.

NON SOLUTIONS

The British National Health Service, US Managed care and their derivatives including Managed competition, purchaser/provider split, co-ordinated care, fund holding, budget holding, regional fund holding, supplier oligopsonies etc have all **demonstrably failed to deliver moderation in the growth of health care expenditure whilst simultaneously maintaining acceptable quality and quantity** in the delivery of health care. Countries that have adopted these approaches or their derivatives are facing escalating health costs together with rising dissatisfaction in the availability of quality medical and hospital treatment. Furthermore since much of this health care expenditure is being financed directly or indirectly by government debt, (future taxation) the burden will fall heavily on future generations.

SOLUTIONS THAT WORK

Singapore's Health Care Financing System is founded on compulsory savings. It features **patient choice** of doctor and facility both public and private, **financial support for the genuine needy**. Medisave, Medifund and Medishield are the 3 main financing modalities supporting a public and private hospital and polyclinic service. **Singapore's medical workforce** delivers the same quantum of high quality health care with **half the number of doctors per thousand of patients compared to Australia** (1:727 Singapore, 1:363 Australia). Cost comparisons which account for the quality of the service delivered shows Singapore's total health care costs to be *"less than half of many developed countries even though its citizens enjoy comparable healthy life expectancy (Watson Wyatt Healthcare Market Review)"*

CHARGE IT TO MEDICARE, THE IMPORTANCE OF PRICE SIGNALS

Australian taxpayers currently spend **$18 billion p.a. on public hospitals** in all States. This equates to around $370,000 per public hospital bed p.a. or $2,000 p.a. for every man, woman and child without private health insurance or $1,000 per person p.a.

In addition every Australian has 11.3 transactions p.a. with the rebatable medical **Medicare** system. This equates to around **220million transactions p.a.** financed by Australian taxpayers.

For many of these transactions the **patient will never know the cost of the service simply because the patient is not expected to directly pay or part pay** for the service, the **bill being sent to a 3rd party funder on their behalf.** Hence, the Australian Health Care financing

system has become a **system of hidden costs** with little if any information flowing to the patient on what has been billed to the taxpayer or health fund on their behalf.

In the case of subsidised pharmaceuticals the **full retail price is also hidden from the patient.**

In contrast the **Singaporean health care** financing system sees the **patient incurring a charge for both public and private services.** In the case of a public hospital ward the charge may be as small as A$16 per day.

Per day hospital charges A$ payable by all patients in Singapore (Ref: Singapore Dept of Health)

Ward type	Public Hospitals	Private Hospitals
A1 – single bed	$161.30 - $352.40	$227.00 +
A2 – two bedded	$152.70 - $168.40	$156.60 +
B1 – four bedded	$105.70 - $133.10	$62.60+
B2 – five bedded	$47.00 - $82.20	
B2 – 6 – 12 bedded	$22.00 - $39.20	
C – open ward	$12.60 - $19.60	

By charging for this service the **patient is able to make choices where possible** of the types of facilities and in some cases, treatment that they are best suited for. These **choices do not compromise the quality of delivered healthcare.** Since the patient is paying from their own savings the incentive is to take a **keen interest in the cost of the service** and to maximise value where possible while still enjoying first quality health and hospital care. When **patients are genuinely unable to pay for their health care costs** they become eligible after assessment for **Medifund to pay on their behalf.** Medifund is administered by hospital social workers.

WHERE'S THE MONEY GOING?

Dissatisfaction with health service delivery **in Australian health care sector** often **generates calls for more government (taxpayer) financing.** It **rarely** results in **questioning why the current levels of funding are not producing adequate services.** Nowhere is this more evident than in the public hospital system. **Despite spending A$18 billion p.a. on public hospitals, we hear persistent calls for more funding. Rarely** if ever do public hospitals or state health departments produced **accurate detailed information on the cost of treatment** and care and/or how costs are allocated (Medical Medicare produces quarterly detailed reports). In the case of **psychiatric hospital care**, we know there has been **significant dis-investment in public infrastructure. Where have the savings gone?** Also with the advent of day surgery in public hospitals driven by **innovations in surgery and anaesthesia, what has happened to the savings generated** by these productivity improvements? **Health care** in general **has become a major catch-all area** in which a **host of programmes and employment opportunities and make-work schemes have been created**, many of which have **no direct bearing on patient care.** This has been described by the Chairman of the Council of Procedural Specialists, A/Prof Donald M Sheldon as the "**closing beds to open desks**" policy.

GAMMON'S LAW & PUBLIC HOSPITALS

Australian public hospitals are increasingly **exhibiting the blights of the British National Health Service**. They are conforming to what is known as **"Gammon's Law"**. **Bed numbers** have been substantially **reduced** even in the face of increasing taxpayer support. **Long waits** have developed in all states for elective surgery (however defined). **Doctors and nurses** working in the system constantly **complain of disruption and dysfunction**. The Australian Society of **Orthopaedic Surgeons** has **offered to double the amount of operating theatre** time its members undertake in public hospitals **with its current workforce** (5-6 hours per week can readily go to 10 hours per week). **No state government has accepted their public offer**. Although founded by various benefactors as essentially community hospitals with independent hospital boards, volunteer community support and some taxpayer funding our **public hospitals have now taken on the worst aspects of government owned and controlled organisations without any of the benefits.**. This is more fully explained in The Australian Doctors' Fund submission entitled, "Towards a More Positive Future for Tasmanian Public Hospitals" (available on www.adf.com.au).

In brief, our **public hospitals have become bureaucratic institutions** infected with the disease of **bureaucratic displacement soaking up funds** that are meant to improve patient care. This disease is well recognised elsewhere. As Dr Max Gammon has pointed out in his 1960s study of the British National Health Service, ***"in a bureaucratic system productivity declines as funding increases"*** – (see Attachment A, Dr Max Gammon's presentation to the Australian Doctors' Fund 25 January 2005).

For this reason, the **direct funding of public patients on a case by case basis** as with the Singaporean system will **allow public hospitals to regain their status** as independent community hospitals with their own hospital boards and ability to engage staff according to their function and purpose and in response to the medical needs of the communities they serve.

RECOMMENDATIONS

In order to meet the first Imperative outlined in this submission, namely *"to establish a means whereby Australians are encouraged to accept greater personal responsibility for their future health care costs where possible, whilst making provision for those who have no means of saving and/or who suffer from chronic illness and need community support"* the following features would have to be adopted:

1. that **Australians be allowed to establish and contribute (pre tax) to their own individual medical savings account** (MSA). This may also be considered as an alternative to paying the Medicare levy. The MSA would then be a vehicle for meeting out of pocket medical and hospital expenses as defined in legislation. The MSA would accumulate if unused in favour of the account holder and/or his/her dependents. The incentive would be for the patient to maximise value where possible and take a direct interest in what is currently hidden transactions costs funded by 3rd parties.

2. **that insurers be permitted to offer insurance to health savings account holders payable from the MSA with pre tax dollars.**

In order to meet the second Imperative outlined in this submission, namely *"To free Australian public hospitals from the constraints placed upon their ability to care for patients because of*

government ownership and accompanying bureaucratic control" the following features would have to be adopted:

1. that **public hospitals be run by independent boards** who have the **authority to take total responsibility for the running of that hospital.**

2. that **a system of charges be set for public hospitals** including bed day rates and pharmaceutical costs which would allow public hospitals to generate revenue for all services provided from patients as per private hospital.

3. for those patients who do not have the ability to pay for reasons of chronic illness or lack of income, **a system of public hospital insurance** would meet their obligations after the assessment of their circumstances. Hence public hospital would have all patients insured and capable of paying for the services offered. This would allow the hospital to align its resources to patient flow and to be rescued from the dysfunction that comes with rationing through block grants. It would also remove the necessity for a bloated management and non clinical functions which absorb current funding better used for the delivery of clinical services.

   Consideration should also be given to **promoting the concept of honorary contracts** for visiting hospital medical practitioners (a system that has deliberately discriminated against by a bureaucracy intent on control). In any event the **medical and nursing workforce** should be **aligned to the requirements as determined by each Independent Hospital Board** and engaged according to health care needs of the communities served by each public hospital as defined by the Board.

Other actions by the Federal Government that would assist to remove the barriers to an efficient and effective health care delivery system both public and private would be:

1. **remove bureaucratic restrictions that prevent or discourage any professional group or industry association from publishing a fee schedule** provided that **coercion to adhere to a particular fee schedule remains outlawed** i.e. remove authorisation and other bureaucratic interventions which simply add to compliance costs and hide price information.

2. insist on the **right of all health professionals, private hospitals and private insurers to set their own fees** to ensure future viability and long term investment in the private health care sector (given the raft of existing consumer protection legislation in all states)

3. **Defund any taxpayer financed programme** or intervention by agencies such as the ACCC which **cannot be demonstrated to an independent board of medical and health care experts to directly contribute to the delivery of patient care.** In particular, closely audit those taxpayer funded agencies which have expanded their "make work programmes" by imposing various obligations on the health care sector which have no purpose other than boosting the self importance of the Agency. The performance of the ACCC and its interventions into the health sector which have added millions of dollars unnecessarily to health care costs and have absorbed hundreds of thousands of dollars of the income of medical colleges which would have been spent on medical training should be the subject of a special independent investigation.

4. Use taxpayer funds to **reinvest in modern health facilities run by independent boards being specifically designed for the treatment and care and safety of the mentally ill**

including the retention and upgrading of existing facilities.

5. **Insist on the re-introduction of the apprenticeship system for nurses training** and the return of the central role of the public hospital in nurse education hence allowing young people to enter early into nursing and align their expectations with the demands of the job prior to a considerable investment in a university degree.

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www.adf.com.au

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Attachment A, "Dr Max Gammon's presentation to the Australian Doctors' Fund 25 January 2005"