Australian Health Association Submission Parliament of Australia House of Representatives Standing Committee on Health and Ageing

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About the Australian Healthcare Association

AHA's role

The Australian Healthcare Association (AHA) is the national industry body for the public healthcare sector including hospitals and other healthcare organisations, aged and extended care facilities, primary care and community health.

AHA has been a major contributor to Australia's health policy for over 50 years.
AHA's members include the governing bodies of Area and District Health Services, Regional Health Authorities, Community Health Services and Hospitals as well as a number of associate and individual members. AHA is governed by a National Council. Councillors are senior health care executives, clinicians, academics and industry leaders from across Australia.

AHA provides high-level advocacy and representation, publishes the Australian Health Review – a peer reviewed health policy journal and the Healthcare Brief newsletter. AHA also convenes an Annual Conference covering a broad range of health sector issues as well as other seminars and workshops on specific issues.

AHA's Vision

All Australians will have access to effective healthcare services that are appropriate and responsive to their needs in all settings, delivered safely by capable personnel providing continuity across the spectrum of healthcare settings (home, residential facility or hospital). Those services must be efficiently delivered and adequately resourced to ensure their sustainability.

AHA's Mission

- To advance excellence in Australian public healthcare services in all settings by promoting the development and implementation of well-resourced evidence-based policies;
- To support a national industry network of hospital and healthcare organisations and to provide high-level representation and information for members;
- To be an independent source of advice, input and analysis for government agencies, media, other industry groups and the community on issues affecting the delivery of healthcare;
- To create a stimulating environment for analysis, review and development of health policy and practice through strategic planning alliances with stakeholders.

Introduction

A nation's health policy should aim for optimal health for every member of its population. This will be achieved through integrating both the traditional approach to curing individual illness and the population health approach aimed at promoting healthy lifestyles and reducing illness and disability among high-risk populations.

In Australia, health policy must involve both public and private sectors in healthcare service provision, health advancement and health evaluation programs. Every Australian should benefit from a needs-based and equitable distribution of high quality services, community involvement in decision-making, a focus on prevention, appropriate use of technology, a multi-sectorial and multi-disciplinary approach and most importantly in a safe and continuous improvement environment. Australia's health system must also be sensitive to its growing culturally diverse populations, and take action to reduce the health inequalities between Aboriginal and Torres Strait Islander populations and non-Indigenous Australians.

There are many barriers and threats to the successful implementation of these aims. These can include leadership, workforce, infrastructure, and cost. For governments, the high cost of healthcare, exacerbated by increasing consumer demands to provide the newer and more expensive technologies and pharmaceuticals necessitates complex resource allocation decisions. For individuals, cultural barriers, cost and distance can also impede access to appropriate services. So while the system needs to be adequately resourced it should also be as efficient as possible to ensure universal and equitable access for all Australians. Significant and immediate investment and innovation is required for all aspects of the system, including capital infrastructure, to ensure long-term viability of Australia's public health system.

Inefficiencies are no more evident than in the duplication of bureaucracies and cost shifting resulting from the lack of agreement on appropriate roles between the Federal and state/territory governments. This is the dominant obstacle to an effective national health system in Australia. A further inadequacy in service provision is created by the inflexibility between health professional groups. Services must be planned to satisfy the needs of consumers rather than be circumscribed by the limitations of traditional professional roles.

The challenges of an increasing burden of chronic disease, disability and mental illness, plus an ageing population, will put further demands on healthcare resources and on an already over stretched health workforce.

In Australia, life expectancy has increased significantly over the past century, reflecting the considerable falls in mortality rates, initially from infectious diseases and, in later years, from cardiovascular disease. Based on the latest mortality rates, a boy born in 2000 was expected to live to 76.6 years, on average, while a girl would be expected to live to 82.1 years, on average. These trends are driven by lower mortality rates at all ages. (ABS 2002. Deaths Australia, 2001. ABS Cat. No. 3302.0. Canberra: ABS).

And the prospect of a longer life often brings with it a heavier disease burden. The growing experience of many Australians is that some two-thirds of their additional years will entail living with a severe handicap.

Life expectancy is not uniform across populations within Australia. Hidden within these figures are two groups whose health status lags behind the rest of Australia. People in lower socio-economic status groups, including those that are unemployed, suffer greater levels of ill health. Indigenous Australians born in the period 1999-2001 are expected to live about 20 years less than the rest of the population.

As well as increased life expectancy, sustained low birth rate is resulting in proportionally fewer young people in the population and, consequently, in the workforce. This has the double effect of potentially reducing the workforce while demand grows and increasing the tax burden for health costs onto fewer people.

Term of Reference a)

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

Background

Australia already has an excellent health system by international standards.

Some of the more positive aspects are:

- The goal of universal access to health care;
- Relatively low cost – at about the OECD average [9.3% vs 10%];
- A growing focus on primary care, reducing unnecessary expenditure on specialist and acute care services;
- Low average infant mortality; and
- High average life expectancy.

However, these general facts conceal specific problems within certain sectors of Australian society, which present current and future challenges to the health system.

For example:

- Poor Indigenous health – Indigenous Australians die, on average, 20 years earlier than non-Indigenous Australians and have correspondingly higher rates of morbidity;
- Unequal access to health services for people in rural and remote areas;
- Increasing rates of obesity, particularly among young people;
- High levels of lifestyle-related preventable diseases, such as melanoma, diabetes and lung cancer;
- An ageing population with a consequent increasing burden of chronic disease; and
- A widespread health workforce shortage, affecting doctors, nurses and allied health workers, intensified by the oversupply of clinicians in metropolitan areas, with a consequent shortfall in remote, regional and even outer metropolitan areas.

Australia must ensure that our health system is equipped to address these challenges, while still maintaining the benefits of our current scheme. This will require a comprehensive review of our health funding system, with the aim of facilitating major changes in how we deliver services.

Duplication is expensive

University of Canberra researcher, Mark Drummond, has calculated that Australian governments could save $2.4 billion a year in public spending by eradicating duplication and overlap in their responsibilities for health and education, with $1.04 billion of the savings funding in health. These savings would go a long way towards upgrading our run-down public hospital system and increasing the numbers of doctors, nurses and other health care workers, and help equip our public health system to meet the rising demand for health care while maintaining high standards of safety and quality.

It would also address some of the seriously under-funded areas in the health system, such as public dental services, aged care, mental health services and Indigenous health. It would reduce the current inequalities of access in health and ensure the most vulnerable and disadvantaged in the community receive the high standard of care they deserve.

The AHA recommends the $1.04 billion a year saved by reducing duplication be spent on the following:

- $104m to upgrade ageing hospital infrastructure, capital stock, equipment and information-communication technologies;
- $50m to upgrade aged care facilities to ensure older Australians who are no longer able to live at home receive the best possible care;
- $200m for additional rehabilitation/step-down facilities for people moving from a hospital setting to the community;
- $100m for a public dental program, targeting children, rural and remote communities, Indigenous Australians and disadvantaged families;
- $150m for additional public physiotherapy, mental health and other allied health services;
- $100m for more nurses in public hospitals, aged care facilities and community care;
- $100m for additional medical specialists in public hospitals and regional/rural areas; and
- $200m for Indigenous health to address the growing health inequalities between Indigenous and non-Indigenous Australians.

Health system changes

Australia's health funding system has not been changed significantly since the introduction of Medicare, over 20 years ago. In fact, one of our largest health programs – the Pharmaceutical Benefits Scheme – is over 60 years old.

But, in that time there have been significant changes in the health care needs of the population.

For example, as we live longer and avoid many of the infectious diseases of the past, the burden of chronic disease is growing. This requires an increased focus on longer-term, multi-disciplinary health care - rather than the short-term, intensive and more medically-focussed interventions that have dominated our system in the past.

Another major change is the exponential advance in surgical techniques and medical practices that allow for much shorter hospital stays than in the past.

Most rehabilitation and convalescing now takes place in the community, either at home or in step-down facilities. This creates increased pressures on both the hospital system, which has to deal with a higher level of patient acuity, and on community-based services such as general practice, which have to provide care for patients coming out of hospital with more complex needs.

It is not surprising these significant changes in the delivery of health care require corresponding adjustments to the structure of our health funding system.

Australia's expenditure on health care has been rising over the past decade, reflecting the experience of many other developed countries.

There are a range of reasons, including increasing consumer expectations, the ageing of populations and the cost of funding new and expensive developments in medical technology and pharmaceuticals.

Health system problems

The AHA believes our current system of funding and delivering health services is far from optimum if we want to achieve good value for money.

The specific problems that reduce the efficiency and the effectiveness of our system include:

1. Inefficiencies, due to cost-shifting and funding duplication between the federal and state governments;
2. A lack of accountability for health funding, due in large part to the federal/state division of responsibilities; and
3. Gaps in service provision due to cost-shifting and deficiencies in integration across jurisdictions.

These problems arise from underlying structures and are not simply organisational or management issues.

Principles for a new system

The AHA believes that Australia needs a new health funding system and we have developed seven principles to guide such a reform process. They are:

1. Clear political accountability for adequate funding of healthcare;
2. Clear accountability of healthcare providers to funders;
3. Clear accountability for safety and quality across all settings;
4. Incentives to ensure that care is given in the most appropriate setting by the most appropriate provider;

5. Integrated planning across jurisdictions, healthcare settings and professional groups;
6. Consumer and community involvement in priority setting;
7. Removal of incentives for cost-shifting; and
8. Increased funding for areas of need.

Meeting these criteria would require major structural reform to our current system.

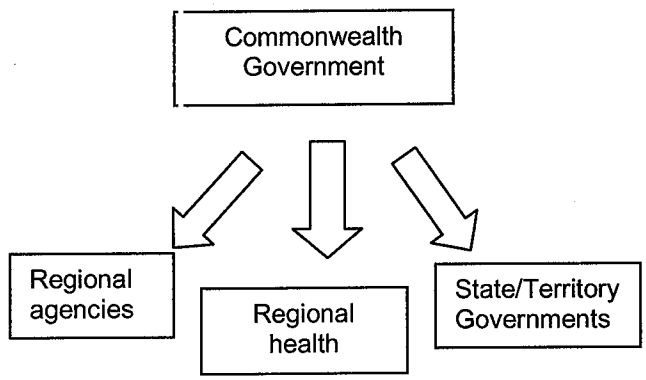
There are a number of options that could be considered.

These include having one level of government taking over responsibility for all public health services. This could be the Commonwealth or, on the other hand, could involve devolving responsibility for all health services to the states. Within these two extreme points on the reform spectrum, there are a number of different degrees of change and variations on how they could be achieved.

Proposed model

There are a number of funding models that could be designed to meet the above criteria. The AHA's preferred model is to have the Commonwealth Government as the single funding body for core healthcare services, including acute hospital care, primary care, pharmaceuticals, residential aged care, dental care and home and community care.

The Commonwealth would provide funding directly to service providers, which could include regional agencies; integrated regional health authorities; Commonwealth/State pooled funding accounts; and/or state/territory governments (particularly in smaller states and territories).



The AHA recommends the development of this model in time for implementation of the next Australian Healthcare Agreements (or their equivalent); the existing Agreements are due for renegotiation in 2008.

This model will support better integration and coordination of services; in particular it will facilitate:

- Establishment of systems that provide coordinated and integrated care across the interfaces between the acute care hospital sector and:
    - *Aged care* (including residential, respite, and community-based care) to ensure quality of life and a positive ageing experience, care is provided in the most appropriate setting;
    - *Primary health care* (including general practice) in order to take the pressure off emergency departments. Joint Federal-state/territory funding will be provided for general practice clinics designed to provide services to ambulatory care (primary care type) patients, particularly after hours. There is an outstanding community need for an effective primary healthcare strategy that recognises the key role of primary health care in improving health outcomes and better integrates primary health care within the health care system.
- Implementation of a national health information and communications network. Such a network is critical to ensuring successful integrated and coordinated care. The network will be underpinned by national standards (privacy, security, confidentiality of data collections and storage, messaging, classification, coding), appropriate architectures, suitable telecommunications infrastructure and incentives for providers to use the system in order to ensure secure and timely transfer of data across all sectors.

Alternative models

However, we acknowledge there are a range of different views within the health sector as to how the reform agenda should be progressed. Reforming the entire health system, all at once, is probably neither politically nor practically achievable. Therefore, a more incremental approach to health care reform needs to be considered.

Consequently, it is important all these options are explored through a transparent and consultative process, before any decisions are made about how to proceed.

Suggested models for a more limited reform of the current system, including governance of public hospitals, include:

1. A National Partnership

A National Partnership is fundamental to successful health system reform in Australia, and should provide access to healthcare services for Australians irrespective of borders or payers. All Australian governments should adopt a nation-wide approach to health policy and service delivery.

The services should provide culturally appropriate services, and ensure equity of access for all sectors of Australia's culturally diverse and Indigenous populations on the basis of clinical need regardless of their geographical location, and income.

A National Partnership will require significant and immediate investment and innovation to ensure long-term cost effectiveness and should incorporate:

- Planning on a nation-wide basis by all governments working together to prevent duplication and service gaps and to overcome competitiveness and cost-shifting;
- Sufficient resourcing through cost-share agreements to ensure services have the capacity to be safe and sustainable;
- National standards governing delivery of services to ensure consistency in quality, confidentiality, outcomes and data;
- Integration and coordination across state/territory borders, program boundaries and care delivery settings (home, residential facility or hospital);
- Nation-wide evaluation of outcomes facilitated by data collections from all levels of government that are timely and based on consistent protocols and formats; and
- Enhanced health service networking and coordinated administration.

In this context, the Australian Healthcare Agreements 2008-13 should govern all public sector health programs and services administered by all Australian governments in partnership. Strategies for the 2008-13 Australian Health Care Agreements should include:

- Flexible funding agreements at the service delivery level facilitated by:
  - Pooling of health program funds and sharing the financial risk resulting from changes in healthcare needs and service requirements.
  - Purchasing of healthcare services through State/Territory-wide or regionally based government/non-government agencies.
- Sufficient resourcing facilitated by:
  - Accurate estimates of growth to meet healthcare needs and service requirements, national health priorities and implementation of a national reform agenda;
  - An indexation formula that properly reflects costs in the health sector;
  - The development and implementation of holistic population based funding models that accurately achieve geographical equity in funds distribution.
- Agreement on national healthcare safety and quality standards and national standards for information management and technology.
- Incentives for a patient/consumer-centred health system through better integration/coordination of services.
- Funding and strategies to address:
  - Infrastructure issues;
  - Workforce issues;
  - Teaching and research functions.
- Nation-wide evaluation of utilisation and performance through collection of timely data on:
  - Volumes of services across all types (not just hospital separations);
  - Access to services (for example, by region);
  - Basic minimum standards for high priority service types;
  - Health outcome, status and effectiveness indicators.

2. **A population group**: A particular population group could be selected and one level of government given responsibility for the funding of all care for this group. This is similar to the existing Veterans Health Program, administered by the Commonwealth.

Older Australians would be a natural population group in which to trial this model, as the gains in better coordinating and managing their complex care needs would be considerable.

3. **A geographical area:** A different approach would be to select a designated region for a small scale trial of pooling all health, aged and community care funding. This could be an entire state or a large regional area. The pooled funding could be administered by either the state or federal government or through a regional health authority. This would provide a comprehensive picture of the impact of changes across all population groups and areas of health and community care.

4. **A stream of care:** Another option involves selecting a single stream of care for trialling a pooled funding model. For example, ambulatory care is currently funded by state governments when it is provided in hospitals and the federal government when it is provided in the community. Handing funding and responsibility for all ambulatory care to a single level of government would remove perverse incentives in the existing system and enable care to be provided in the most cost-effective and clinically appropriate setting, taking into account the needs of consumers.

5. **A health program:** Another option is to focus on a health program that is currently split between federal and state governments and to hand over funding and management responsibility for it to one level of government. For example, funding for pharmaceuticals is currently split between the federal and state governments depending on whether patients receive medication in hospitals or in the community. Pooling funding for the pharmaceuticals program would help achieve greater efficiencies and provide consumers with their medication in the most convenient setting for them.

Term of Reference b)

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

Background

As stated above, the existing dual public hospital funding arrangements leads to lack of accountability (the 'blame game') and creates problems in terms of day-to-day service delivery.

Single funder

AHA supports a single funder for all public health services and this should be the Commonwealth Government.

Integration of funding does not require any change to existing management and operational arrangements, indeed local, regional and state innovation, planning and priority setting are essential elements of the health system and should continue.

This new arrangement should be implemented in the next Australian Health Care Agreements commencing in 2008. The Agreements should also provide for national standards to ensure consistency in quality, outcomes and data; and facilitate co-ordination across state and territory borders, across program boundaries and across care delivery settings.

Public hospitals and community health services should be eligible to refer patients for access to allied health services/providers and dental services, and public hospitals and community health centres should be able to claim for these benefits, subject to maintenance of effort requirements.

Culturally appropriate primary health care should be available to all people, regardless of where they live, their income or their health and related problems. Increasingly primary health care is being recognised as the cornerstone of modern health care and as the 'gatekeeper' for specialist services.

An effective primary health care system should:

- Provide early intervention through health promotion strategies;
- Focus on disadvantaged population groups to overcome inequities in health outcomes for and targeting work with particular groups;
- Provide a seamless service (continuity of care) through strategies such as case management, care pathways, coordinated care;
- Have a holistic approach as well as dealing with the presenting health issues;
- Defer the onset of chronic disease and disability through early detection and management; and
- Strengthen consumers' management of their own care through a consumer-centred model of service provision with a focus on education and involvement in decision-making.

Integrated involvement of both public and private sectors in service provision, health advancement and health evaluation programs is necessary to ensure access and avoid duplication of services.

Term of Reference c)

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

Background

Processes must be transparent and open to allow for representative consumer and community involvement in decision making. It is no longer acceptable that systems and institutions exclude consumers. In addition, change can only be achieved with the broad support of the community.

It is also critical that the system develops and continues to apply valid, reliable and sensitive outcome measures and that the results are published in comprehensive and timely reports to the community and stakeholders.

An emphasis on quality health outcomes is the measure of a safe health system. Economic factors should not be the primary determinant of the allocation of funds for health. However, it should be noted that, by increasing safety and reducing adverse events, the cost of care will be reduced and improved health outcomes will be achieved.

National standards

National standards for quality and safety in healthcare services are necessary. The standards should ensure:

- Sufficient funding for high level scientific research and evaluation on the measurement and improvement of patient care, health status and outcomes subject to regular reporting on national trends and disparities in quality;
- The use of standardised information to create effective linkages between sources of health information from regional and local levels;
- Quarterly analysis of data on high-level adverse events;
- Active consumer involvement and public access to an annual report of national adverse events;
- Increased resourcing for safety and quality improvement;
- Workforce reform focused on a multi-disciplinary team approach to care underpinned with education and training programs that encourage a culture of safety and greater openness in the system;
- Evidence-based practice as part of routine service delivery;

Community consultation

A comprehensive consultation process with the community should be absolutely central to any reform. Currently, there is no systematic process to obtain the views of the Australian community on their priorities. Despite the fact consumers are both the funders and the users of health care, governments and policy makers do not have a good idea of what the community wants from the health system.

This is a serious gap.

There are many tough questions that need to be asked in allocating health funding. Should we be putting more resources into saving premature babies or into reducing the rate of smoking in the community? Should we increase access to health care to rural and remote communities, if this means reducing access for those living in cities?

Unless we have a community debate about these issues, we will not have a health funding system that truly reflects the views and priorities of the Australian people.

There are many examples of how community consultation on health priorities can work. Some of these, such as the "*Oregon Experiment*" in the United States, have been fairly controversial.

However, there are two recent examples of successful community involvement in determining broad priorities for health system funding which are discussed briefly below.

These are the *Romanow Commission* in Canada and a smaller scale *Citizens' Juries* project in Western Australia.

Canada - Romanow Commission: The Commission on the Future of Health Care in Canada (commonly called the *Romanow Commission*) was an independent Royal Commission established in 2001 by the Prime Minister of Canada, to examine broad structural issues affecting the Canadian health system. The Commission undertook an extensive program of community consultation, including: 21 open public hearings; 12 "citizens' dialogue" sessions focussed on specific issues; hundreds of formal submissions; and 14,000 online surveys.

At the end of this process, the Commission concluded the vast majority of Canadians supported the principle that access to health care should be based on need, rather than ability to pay. The consultations also revealed strong community support for: an increased focus on primary and preventive care; additional funding for rural and remote health; and action to remove health inequalities between Indigenous and non-Indigenous Canadians.

Australia – Citizens' Juries in WA: These findings reflect those of a much smaller consultation process in WA in 2000 and 2001 where "*Citizens Juries*" were established to advise on health care principles and priorities. Members of these juries were randomly selected from the electoral role and provided with information about the health status and cost of providing services of different population groups.

The juries were then given a hypothetical budget and asked to allocate it between competing areas of health care; for example, between rural and urban services, Indigenous and non-Indigenous populations and aged and non-aged care.

The juries were able to agree on funding allocations across these areas, and placed the highest priority for spending their hypothetical budgets on providing services to Indigenous populations.

This process demonstrated that, with adequate information, citizens are both willing and able to deal with complex ethical and conceptual questions in health, and provide meaningful advice on broad issues underlying health resource allocation.

The *Romanow Commission* and the *Citizen's Juries project* provide good examples of how the community can be involved in determining underlying principles for the health system and allocating funding across different program areas and population groups.

Term of Reference d)

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

Background

A disturbing pattern is developing where every year, the Government approves substantial funding increases for the private sector, while letting the public hospital sector fall further behind.

Private vs public funding

This year, the Federal Government has approved a 7.96% private health insurance (PHI) premium increase and last year it was 7.5% - in fact, the cost of private health insurance has gone up 33% in the past four years.
However, during the last two years the public system was given only an annual 2.1% increase. This is widening the funding gap between the public and private hospital systems. It is argued that the costs of private health care are rising due to increased medical costs and the cost of expensive devices and new technologies. These factors apply equally to the public hospital system. In fact, some of the most expensive and technologically complex procedures are only done in public hospitals because they are too expensive for the private sector to undertake.

The AHA supports a robust private hospital sector to complement Australia's public hospital system. However, the public hospital system remains the backbone of Australia's health system – 70% of total patient days in hospitals are provided by the public system. Public hospitals also provide the vast majority of emergency care and treat three times as many children under 5 as do private hospitals.

Increasing subsidies to the private system without equivalent increases to public hospital funding will attract scarce resources, such as medical specialists, away from the public system. This will result in longer waiting times for public patients and restrict the ability of the public sector to provide high quality care.

Support for the private health system should not be at the expense of Australia's public health system. The AHA urges the Federal Government to match its funding increases to the private sector with a similar increase to public hospitals.

Complementary roles

Subject to equality of funding, the AHA supports complementary and supporting roles between the public, private and not-for-profit industry sectors to avoid duplication of resources, including:

- Role delineation of hospitals based on their geographical locations and the needs of the population for access to elective and emergency services, preventative services, health education and health promotion; and
- Authorisation of selected private sector facilities for use by public sector providers and consumers to prevent duplication of capital infrastructure.

Term of Reference e)

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

Background

Private health insurance (PHI) is available for the following services:

- Admitted hospital care in a registered public or private hospital and day surgery centre;
- Services delivered by a registered medical practitioner to an in-patient (for the difference between 75% and 100% of the MBS schedule item or a negotiated scale determined by a Private Health Insurer); and
- Extras cover for a range of non-medical healthcare services, and lifestyle related services.

Approved health insurance products are eligible for a subsidy of 30% without means testing. High income earners not taking out health insurance are required to pay an additional 1% Medicare levy. Community rating has been replaced by Lifetime Healthcover. This penalises persons taking out PHI after the age of 30 by applying an age adjusted loading on premium of up to 60%.

Legislation has been introduced which requires funds to offer No Gap and Known Gap (Medical) policies coupled with a requirement for greater disclosure of costs and "contracts" prior to care delivery.

There is a concern that as more people opt to take out PHI and use the private healthcare sector, then there will be less societal concern for investment in the public healthcare sector. One logical outcome of such a trend is a two-tier system, with the public system operating as a safety net for the poor.

PHI investment as taxation policy

An alternative is to view the Commonwealth's investment in private health insurance as taxation policy, rather than as health expenditure. While ever there remains the option for insured people to be admitted to public hospitals as public patients, PHI as a potential source of health expenditure remains just that – potential expenditure.

The incentives offered by the funds for the insured to use their insurance (ie elect to be admitted to a public hospital as a private patient) is an important factor. Recent initiatives proposing "no claim bonuses" work against the spirit of Lifetime Healthcover, and further encourage the selective use of the product.

Impact of 30% rebate on public hospitals

When the current Government introduced the 30% rebate for private health insurance premiums it stated this would take the pressure off the public system. The Government, along with private health insurers and private healthcare providers, argued that if more people took up private health insurance, private hospital activity would increase, thus reducing demand and waiting times in the public hospital system.

However, evidence from the UK and Canada suggests that a higher take-up of private health insurance is associated with longer public waiting lists. One reason for this is that the same doctors work in both the public and private system. As doctors generally get paid more in the private system, they have a perverse incentive to keep patients on waiting lists for longer so that they are more likely to access treatment privately.

Results from a study by Professor Stephen Duckett, Professor of Health Policy at Latrobe University, found that increasing support for private health care has led to longer waiting times for patients in the Australian public hospital system, confirming international research. This is the first Australian study to test whether the Government's stated aims for private health insurance subsides are confirmed by data. Reducing waiting times for public hospital treatment would benefit the thousands of Australians currently on hospital waiting lists. However, this study shows that Federal Government policies supporting private health insurance may actually increase waiting times for hospital treatment.

This study used hospital data from the Australian Institute of Health and Welfare to analyse the relationship between waiting times for specific procedures and the proportion of those procedures that occur in the public system. The analysis showed that shorter waiting times were associated with a higher level of activity in the public sector.

A more effective way to decrease waiting times in the public sector is to use private health insurance subsidies to directly fund public hospitals [AHR Vol 29 N0 2].

Impact of 30% rebate on PHI members

According to another new study by the National Centre for Social and Economic Modelling (NATSEM) under a grant from the Australian Research Council, the 30% rebate and Lifetime Health Cover dramatically increased PHI membership numbers, but mainly among the higher income population. The study also found that the 30% rebate could be removed without having a significant impact on the numbers of people with private health insurance.

Using a recently upgraded PHI model, the impact of government policies on the rates of people with PHI over the period from 1993 to 2010 was examined. The study found that there was virtually no increase in the uptake of private health insurance following the introduction of the 30% rebate and that there is very little difference in the numbers of people projected to have PHI by 2010, regardless of whether or not the 30% rebate is retained. However, significant increases in private health insurance membership came when the 30% rebate was joined by Lifetime Health Cover - and the increases were much greater among the most affluent 20% of Australians than among the rest of the population.

This research found that the 30% rebate and Lifetime Health Cover were doing little to improve the use of PHI by the poorest in society. Even with both these policies remaining in place, the model predicts that by 2010 only 27% of people in the bottom 40% of income earners will have PHI, compared with 75% for people in the top 20% of income earners.

Relationship between PHI and use of private hospitals

The research also looked at the impact of income level on access to PHI and private hospitals. Even among Australians with private health insurance, those with high incomes used private hospitals more intensively than the low income groups. This may reflect a fear of gap payments among people on low incomes so that they use public hospitals even though they have PHI. This means that even when people on low incomes have PHI, their access to private heath care may be less than those with more resources.

Not withstanding the terms of reference given by the Review, the AHA recommends that the Government reconsider the 30% rebate as, given the evidence cited above; the policy is not easing the burden on the public health system. This investment is increasingly difficult to justify in terms of effective use of the health dollar.

Prue Power
Executive Director
Australian Healthcare Association

26 July 2005