CATHOLIC HEALTH AUSTRALIA

SENATE INQUIRY INTO MEDICARE

18 JUNE 2003

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MEDICARE

Contents

1.0 Executive Summary

Catholic Health Australia is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities, and related organisations and services. CHA seeks to be an active participant in the health policy debate. In undertaking its advocacy role CHA seeks to promote the goal of a health care system that values respect for human dignity, is person-centred, has a special concern for the poor, the common good, the appropriate stewardship of resources, and delivers social justice.

CHA welcomes the opportunity to contribute to this Senate Inquiry on Medicare.

CHA contends that it is only appropriate to consider any reform to Medicare in the context of the wider economic, social and demographic changes that are occurring in Australian society. Consideration of the future of Medicare as it specifically relates to general practice in isolation is fraught with danger. Any reforms should only be undertaken in the context of considerations in the Australian Health Care Agreements, broader Commonwealth-State Grants arrangements, and inter and intragenerational transfer issues.

Medicare as it relates to primary health care and the rest of the health care system is public health insurance and is an integral component of the social contract between government and the community.

CHA contends that the proposed reforms to general practice remuneration potentially undermine the concept of a shared public health insurance arrangement, shift costs to individuals with most relative negative impact on those families earning low to middle incomes, and those with chronic illnesses such as cancer and mental illness, while lacking any compensation for those most at risk. Its proposed safety net extensions only apply to those receiving existing concessions through health care cards.

Therefore, CHA does not support the proposals for Medicare reform put forward by the Federal Government as they currently stand.

CHA does support the proposals relating to workforce issues for general practitioners, nurses and allied health professionals that were simultaneously announced, and which it believes should be considered separately from the Medicare reform issues.

CHA supports Medicare as an entitlement program that is properly funded and indexed. In the context of the Government's continued pursuit of increased user charges under this proposal, that fundamentally undermine Medicare as an entitlement program, the following measures that seek to retain the notion of entitlement are demanded:

- Increase the MBS rebate to a more appropriate level that remunerates on the basis of fair value for the service provided.
- Implement an appropriate indexation formula that takes into account increased health care costs.

- Provides an incentive payment to those general practices that achieve a set target of bulk billing.

To attract any support, the proposed reforms must address the issue of compensation for those who will potentially be most disadvantaged by the erosion of Medicare as a public health insurance product. If the medical profession does not take up the offer, no extra funding gets directed to health care and the Government achieves a $917m saving, as all Australians begin to pay more at the point of service.

Those doctors who may have intended to continue to provide a relatively high level of bulk billing in city areas to ensure market volume may be attracted to the extra $1 per consultation. But the gate is now potentially open for them to limit their bulk billing to only those with a health care card and begin to increase their income by applying increased copayments to those without a health care card. The proposal effectively creates a means test – not to be administered by the government, but to be administered by the GP.

- The $1-$6.30 incentive should only be payable to those doctors who achieve a set target of bulk billing. Any target should be matched with appropriate funding.

The only safety net offered to those with no concessional benefits is an opportunity to purchase additional private health insurance at a cost of $1000 plus.

While targeted compensation through the extension of health care cards to an increased number of low income families is less attractive than retaining an appropriately indexed MBS that encourages doctors to retain bulk billing more broadly **for all Australians**, its very suggestion demonstrates the major weakness and inequity in the Government's proposal. However, a proposal that increases the number of concession card holders will not deliver as much potential income to doctors who take up the Government's offer, and simply shifts the burden to users a little higher up the pay scale to wherever the arbitrary concession card entitlement stops. It potentially limits the number of people who may be required to pay a copayment under the proposed new arrangements but increases the quantum of copayment that group is likely to be charged as doctors seek to cover their practice costs and build in their expected income to their pricing arrangements. Further, compensation packages by their very nature become diminished in value over time.

The convenience of 'swiping the card' is superficially attractive and electronic technology that is geared towards improving administrative efficiency of the system is welcomed. It should stand or fall on its merits and should not be used as a mechanism for potentially further discriminating against those who are not fortunate enough to reside in an area that has doctors who sign up to the Government's proposal. It is argued this initiative could be implemented irrespective of the proposed reforms that will only allow it for those who find doctors who take up the Government offer.

- A mechanism already exists and is widely used in diagnostics for the service provider to directly charge the patient a copayment only upfront, and seek remuneration of the rebate through the HIC later.

In summary, the proposals mean that people's insurance purchasing power is worth less, and the relative impact on those on low to middle incomes and with the highest

level of health care needs is greatest and most inequitable. The reforms as they are currently presented are unacceptable.

Inquiries about this submission are welcome and may be directed to:

Catholic Health Australia
PO Box 330
DEAKIN WEST ACT 2600
Ph: 02 6260 5980 Fax: 02 6260 5486 Mob: 0418 486 440
Email: secretariat@cha.org.au
Web: www.cha.org.au

FRANCIS SULLIVAN
Chief Executive Officer
20 June 2003

2.0 Recommendations

Catholic Health Australia calls on policy makers, government and all parties to support Medicare through the following measures:

1. Support the proposal to direct $257.3m to workforce initiatives for 150 new general practice training places, 234 extra medical school places per year, and funding for practice nurses and allied health workers.

2. Support Medicare as an entitlement program. Any reform to the system should not have inbuilt incentives that induce service providers (inadvertently or not) to limit bulk billing to a select and targeted group of the population (ie concession card holders).

3. Fund and index the MBS appropriately, drawing on savings from other identified areas of the budget, and taking account of community support for appropriate social spending rather than reduced taxation.

4. Remove ancillary private health insurance products from the scope of the 30% rebate arrangements and direct funds to targeted areas in the MBS or the AHCAs.

5. Consider a range of options of reform of the 30% rebate that would contribute to the improved equity and efficiency of private health insurance arrangements.

6. Reconsider current proposals before Parliament such as the introduction of increased copayments on pharmaceuticals due to their regressive impact on families with low incomes and children, and those with a chronic illness.

7. Consider a range of reforms aimed at increasing older persons' participation in the workforce, reforming taxation on superannuation, increasing superannuation guarantee level, establishing long term health and aged care savings schemes, and introducing an entitlement based aged care benefits schedule, for the purpose of increasing options for future health care funding.

3.0 About CHA

3.1 The Catholic Health, Community and Aged Care Sector – Background

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

The sector comprises providers of the highest quality care in a network of services ranging from acute care to community based services. These services have been developed throughout the course of Australia's development in response to community needs. The service providers carry on centuries-old traditions of bringing Christ's healing ministry to those who suffer – the ill, the disabled, the elderly, the disadvantaged, the marginalised, the poor, serving those that others with a profit motive do not. The services return the benefits derived from their businesses to their services and to the community; they do not operate for profit; they are church and charitable organisations.

The sector plays a significant role in Australia's overall health care industry, representing around 13% of the market and employing around 30,000 people.

The Catholic health ministry is broad, encompassing many aspects of human services. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans health, primary care, acute care, non acute care, step down transitional, rehabilitation, diagnostics, preventive public health, medical and bioethics research institutes.

The Sector Snapshot

17000 residential aged care beds
5312 independent living and retirement units
4399 community aged care packages
4729 home and community care services
58 hospitals
7800 hospital beds
38 privately funded hospitals
20 publicly funded hospitals
7 teaching hospitals
17 rural and regional hospitals
157 rural and regional aged care services
publicly and privately funded collocated facilities
across six states and one territory

3.2 Advocacy Goals

Catholic Health Australia seeks to be an active participant in the health policy debate. In undertaking its advocacy role CHA seeks to promote the goal of a health care system that values respect for human dignity, is person-centred, has a special concern for the poor, the common good, the appropriate stewardship of resources, and delivers social justice.

CHA continues to work for a fairer health, community and aged care system. It calls for policy initiatives, legislative reforms and funding models that are geared towards the achievement of a just system and a system that facilitates service providers and individuals to better meet the community's needs.

Catholic health, community and aged care providers seek to develop ministries that

are steeped in the values of our heritage and Catholic tradition.

The foundation and reason for the church's healing ministry is the healing and redeeming ministry of Jesus. Catholic health care is committed to the dignity of the person made in the image of God, an image that unfolds over a lifetime.

This commitment to the continued nurturing and growth of the ministry is based on a Catholic understanding of social justice; respect for diversity; a commitment to equity, access for the most marginalised, excellence in service and responsible stewardship; and the courage to embrace creative change.

3.3 Foundational Principles

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

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

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

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

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

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

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

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

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

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

The submission will be argued predominantly from the principles of human dignity and respect for human life, solidarity and the common good, and the linked principles of subsidiarity and socialisation.

Efficiency at the price of equity undermines the social fabric. The principle of common good holds that individual fulfilment should not be at the expense of the social wellbeing of all people living in the community. The principle of Solidarity and Common Good involves a vision of society and our relationships with one another. Solidarity is not a vague feeling of compassion or shallow distress at the misfortunes of people. It is a firm and consistent determination to commit oneself to the common good, to the

good of each individual because we are all responsible for that.[1] Such concepts are at the core of Medicare. The strength of community support for Medicare says a great deal about the values held by many Australians regarding community solidarity.

The foundation and reason for the Church's healing ministry is the healing and redeeming ministry of Jesus. Of central importance to Catholic social teaching is the fundamental notion of human dignity. Catholic health care is committed to the dignity of the person, each with an intrinsic and inalienable right to life. Human dignity is a free gift from God; it does not depend on human effort, work or accomplishments.[2] Building on this principle, health care is a social and personal good. It is a service, not a commodity used for maximising profit.

Catholic tradition holds that goods and burdens of a community are to be distributed on the basis that not all persons can contribute in the same way. Wherever possible burdens should be distributed equitably with due emphasis on a persons capacity to contribute.[3]

In line with the linked principles of Subsidiarity and Socialisation it is important to balance the need for effective services with the need for freedom and pluralism; we should not take from people their right to help themselves. Our services should enable people to take power over their lives rather than becoming dependent. At the same time society has a responsibility to recognise suffering that is so entrenched by our economic and political systems that the actions of families and individuals is inadequate to meet their needs. So while we should not necessarily rely on governments first to solve every social ill, nevertheless, the nature of society is such that governments should play a role in essential services such as health care.

It is from these premises and the principles underpinning them that CHA advocates for maintenance of the Medicare system as an entitlement program, and seeks reform that strengthens its positive characteristics, rather than undermining its foundations.

[1] John Paul II, 1988, No 38 cf Mark Raper SJ, "Catholic Social Teaching and Strategies for the future in the Contemporary Australian Context", Address at the annual conference of Catholic Welfare Australia, Sydney 21 August 2002; Rerum novarum, n.28-29; Mater et Magistra, "Christianity and Social Progress" (1961), Pope John XXIII, n.65; Gaudium et spes, n.74.
[2] Centisimus annus (1991), nn.53-62; Gaudium et spes, n.12, n.22.
[3] Mater et Magistra, n. 132; Rerum novarum, n.27.

4.0 Medicare

4.1 The Value of Medicare

Equality of all persons comes from their essential dignity.

Access to essential health care should be based on need and not capacity to pay.

Within an environment where federal, state and territory governments are increasingly setting the policy parameters and frameworks around 'user-pays', the Australian population continues to support the thrust of universal and equitable entitlement to health care through the Medicare public insurance system. As an entitlement program, Medicare relies on community solidarity to sustain and fund it as a comprehensive health care system for all.

The main threat to Medicare remains sufficient public funding to guarantee access based on clinical need – funding shortfalls are not only evident in primary health care, but are a perennial problem across acute care, pharmaceuticals, aged care and community care. Catholic public hospitals, palliative care and mental health services, residential and community aged care, and disability services continue to struggle to meet demand in the face of inadequate funding from Commonwealth, state and territory governments, and other funders. Catholic private hospitals continue to have difficulties accessing appropriate funding from health funds in meeting the health care needs and expectations of private health fund members.

Even though Medicare is predicated on a principle of equity of access according to clinical need, expanding demand and scarce public resources leads to circumstances in which access to a range of essential services can always be improved. Our health system is under pressure, but it is still fundamentally sound, and the envy of most other nations. CHA advocates for reforms that improve the existing system to ensure optimal equitable access to health, aged and community care for all Australians.

The significant ongoing role of public financing of health and aged care must remain, to ensure distributional equity. It is a mark of our regard for each others health that we are prepared as a community to invest in the effectiveness and efficiency of universal insurance.

As public policy debate heats up regarding possible interventions to shore up the nation's Medicare entitlement program, it is important that policy makers fully appreciate the role of church and charitable providers in meeting the needs of vulnerable populations, whose health care needs may otherwise remain unmet.

While regarded as one of the most effective and efficient systems in the world, the Australian health care system is complex, involving multiple funders and providers. CHA considers that the goal of the health system as articulated by Scotton as 'universal access to medically effective care at least cost' is valid and worth continuing to pursue.[4] Medicare is a vital component of the health system. Its various elements and underpinning characteristics are integral to achieving this goal, shaping the overall health system's equity, efficiency and effectiveness.

[4] Dick Scotton.

4.2 Health Care as a Social Good

CHA believes that health care is an essential social good not merely a commodity that is used to maximise return on investment to meet the economic interests of private shareholders. Social goods form the fabric of our society and belong to us all. They benefit us all through the realisation of a better society, and therefore need to be funded by the community, not just by those using them. The delivery of social goods brings with it a community responsibility. Individuals may participate by way of contributing where they can, but should not be burdened to the point that their contribution disadvantages them from accessing other essential social goods of life.

4.3 Equitable Access

4.3.1 Rural Health [ToR (b)]

An area of particular concern with regard to access to essential health care services is rural and regional Australia. Medicare Benefits and general practice remain relatively less accessible to those living in rural and remote Australia. The people of rural and regional Australia are entitled to equitable access to the entitlement of Medicare. A primary mission of Catholic health providers is focussed towards those most marginalised and at need in our community, and the ethos of social justice and equitable distribution of health resources according to need are central to their purpose. With 17 acute and non-acute health care facilities and over 150 aged care facilities located in rural and regional Australia, the Catholic sector is well placed to use the infrastructure of these facilities as a springboard for supporting properly funded community based services and multi purpose centres.

As GPs require incentives to maintain a presence in rural and regional Australia, so too is there a need to encourage the continuing presence of health and aged care facilities and other workforce participants on whom these facilities rely.

It is important to continue to introduce incentives to ensure a fairer distribution of GPs in areas of low socio economic status and with a particular emphasis on rural and remote areas[5]. These measures could involve differential MBS payments, training, practice grants and support, family support, vocational relief and peer support programs.

Maintaining access to a high quality nursing and allied health professional workforce requires a multi-faceted strategy. Measures could involve: supporting clinical training places and HECS payments; additional scholarships; providing financial incentives for employment in regional and remote locations; and, supporting workplace salaries and conditions to attract nurses back to the profession.

CHA has called for such measures in its recent submissions and welcomes the Government's commitment to workforce strategies announced in its Medicare reform proposal.

Recommendation 1: Support the proposal to direct $257.3m to workforce initiatives for 150 new general practice training places, 234 extra medical school places per year, and funding for practice nurses and allied health workers.

[5] Independent research conducted by Jesuit Social Services, 2001.

4.3.2 Oral Health

Good oral health is fundamental to the quality of life and dignity of people. Like many other health issues, it becomes an increasing problem with age. [ToR (d) (i)] Pensioners and others on low incomes have suffered most in the dramatic reduction in access to oral health services through the discontinuation of the Commonwealth Dental Health Program. The National Dental Health Alliance estimates that there are some 500,000 Australians waiting for public dental services, many of them pensioners waiting years for dentures.[6] This is not a compassionate and just way to treat older Australians. It reduces quality of life for the most vulnerable and increases longer term health care costs through its associated impacts.

The inequity of this situation is further highlighted when considered in the context of the current public subsidy for ancillary private health insurance (see also section 5.2).

4.4 MBS Rebates

CHA is concerned that the Government's proposals aimed at seeking to address the current anomalies in the MBS for general practitioners, potentially undermine the principles on which Medicare as an entitlement scheme is based. CHA contends that if it is the Government's judgement that general practitioners are not being appropriately remunerated through the MBS (and this is the AMA's and Productivity Commission's judgement), then that issue should be addressed directly. The real cost of care should be funded and funded equitably. [ToR (d) (iii)]

The Government's proposal introduces further unnecessary administrative complexity and uncertainties into the system, exacerbating perceptions of a tiered system. Appropriate MBS rebates that are realistically indexed (with a differential applying to rural and remote areas if necessary) represent a more transparent mechanism than creating administratively burdensome programs that will be required to ensure that GPs who take up the Government's offer actually comply with all of its requirements. It is difficult to anticipate that a GP who may be currently charging a fee of anywhere up to around $25 above the MBS rebate would be induced to take up the Government's $1 to $6.30 offers along with its administrative burden. It is not clear from the Government's proposal if this same quantum of incentive will apply to higher cost long consultations and after-hours and home visits. [ToR (b), (c), (d)]

While there may well be an argument for making available private insurance products to cover primary health care, and greater opportunities for electronic technology to reduce administrative costs, the way in which this proposal is proposed to be implemented is argued to discriminate against the most vulnerable.

Under the Government's proposal:

- Low income earners with a health care card may retain the right to be bulk billed, depending on their general practitioner's decision to offer that service. [ToR (c) (i)]

- High income earners will have the choice of taking out private health insurance to cover the gap in doctors' fees. Further, high income earners can more readily carry this cost and in effect are compensated by the very fact that they are better off. [ToR (c) (iv)] There is a lack of information currently about the potential cost of this insurance. In the 1980s when this idea was last promulgated, the gap insurance

[6] National Dental Health Alliance: Stop The Rot Campaign.

was around $5 per week for a family. It would be difficult to believe it would be less than $10 per week now. Reports of this insurance costing $1 per week do not appear to be based on actuarial assessments. It should also be noted that at whatever level the private health insurance for primary health care is introduced, it would be expected to attract at least CPI increases and more likely increases of around 7% per annum in line with other health care cost increases.

- Low to middle income earners and particularly those with chronic illnesses such as mental health and children who are concerned about the availability of bulk billing will feel increasingly compelled to take out private health insurance, when they have little discretionary income available to do so. Further, even with that private health insurance, they cannot access its benefit until they effectively pay a front end deductible of $1000. That $1000 should be considered as part of the cost of the private health insurance product in addition to the premium cost. [ToR (c) (iv)]

- Low to middle income earners with no health care card access and no certainty about bulk billing availability may not be able to afford private gap insurance, and will not have a clue about how much it is going to cost them to visit the doctor. [ToR (c) (iv) There is no compensation for the continued erosion of their public health insurance that they believe they were entitled to in the past through a progressive taxation system and their contributions through the Medicare levy.

The proposal as it currently stands potentially puts in place an incentive for doctors to introduce increased copayments to those on low incomes and without a health care card (through the convenience of the swipe card) but does not provide compensation for those least able to afford that potential increase. If the government's additional $1-$6.30 increase is inadequate to cover doctors' practice costs and income expectations (as doctors' representational groups and many other commentators argue), there is a very real chance that those same doctors who might happen to take up the government's offer will seek compensation through those eligible for the copayment.

The inducement of the swipe card that on the surface reduces the amount the patient has to take out of their wallet in the first instance, does not change the fact that what is left in their wallet at the end of the episode may well be much less than currently occurs. Avoiding the visit to the HIC Medicare office may end up costing more. A copayment is a copayment whether its full effect is felt at the point of service or later on at the Medicare office. Add to this scenario, the government's proposal to increase pharmaceutical copayments, and not only are individuals who visit the doctor potentially worse off financially, but the implications for Australia's longer term health outcomes and sense of community responsibility for health care are stark.

While Government and officials can argue that the proposal in itself does not induce doctors to increase their fee and further inflate health care, we as a community have no way of knowing this until it happens or does not happen at implementation. Furthermore, we may never know the full impact of the proposal on certain groups and populations after it is implemented as the complexity of the system distorts the statistics. There is a vast difference in the current rate of bulk billing between different areas of Australia. While the Australia wide number is 68.5%, in some areas it is well below 40%. Even though all Australians will theoretically continue to have access to a Medicare rebate, people on low incomes will find the value of their Medicare entitlement is eroded as their rebate only goes part of the way to meet the doctor's

bill. [ToR (c) (ii)] Certainly it can be argued that this is the current reality for many already. But as the gap further widens between the rebate and the amount the individual is expected to copay, the capacity of those on low incomes to meet the shortfall from their discretionary income diminishes. CHA argues that the current reality is not good enough either, and it does not support the further erosion of Medicare as the public health insurance **for all Australians.**

Recommendation 2: Support Medicare as an entitlement program. Any reform to the system should not have inbuilt incentives that induce service providers (inadvertently or not) to limit bulk billing to a select and targeted group of the population (ie concession card holders).

Recommendation 3: Fund and index the MBS appropriately, drawing on savings from other identified areas of the budget, and taking account of community support for appropriate social spending rather than reduced taxation.

5.0 Public and Private Health Interface

The Catholic sector maintains a significant presence in both the public and private sectors; in some cases as collocated privately and publicly funded health care services; in other cases as collocated health and aged care services; and increasingly using existing infrastructure as a springboard to home and community care delivery. CHA supports reform that underpins a mix of publicly and privately funded health care services.

5.1 Private Health Insurance and Perceived Inequities

The private health industry has been the focus of reform initiatives for some time because of concern to maintain the private sector option as a viable complement and supplement to the public sector, not a parallel alternative, and because of its necessary interface with the public health care system. Health care is not a commodity. However, it is recognised that costs are a factor, hence efficiency in delivery and effective outcomes are important in the context of considering competition in health care. Because of this it has been argued 'the issue is not about free markets, but rather about the optimal regulation of markets'.[7]

Furthermore, Medicare was not designed as a safety net although some current rhetoric might seek to increasingly cast it in those terms. It relies on community solidarity to keep it sustainable and available as a comprehensive health care system for all. But equally CHA supports the underpinning policy around the 30% rebate that was when it was introduced articulated as being about ensuring the private health care system operates as a viable complement to the Medicare and public hospital system. CHA supports public assistance for people who use private health services. As Wright has argued, in the main the privately insured are not 'takers from the system'.[8] Their 70% contribution to health insurance, while giving them some personal benefits, also contributes to the long term sustainability of the entire system. It is inappropriate to consider the Australian health care system in an either/or public vs private construct. The diverse nature of the system brings both challenges and strengths; it is a system that CHA believes is worth maintaining albeit with some room for improvement.

CHA argues that support for the notion of a private health care rebate is consistent with a policy of universal health care; government subsidies apply to both the MBS and the PBS. In the case of the MBS and the PBS the subsidy applies at the point of service delivery. The principal concern with the current structure of the 30% rebate is that it is not entirely consistent with other government subsidies; instead of applying at the point of service, it supports insurance. Its structure introduces anomalies and inconsistencies by not directly supporting the delivery of health care services. The application of a 30% rebate to out of hospital private medical insurance instead of at the point of service extends this anomaly into yet another area. [ToR (c) (iv)]

While the $2.4 billion per annum Commonwealth expenditure on the private health insurance 30% rebate, along with the introduction of Lifetime Health Cover have had benefits in stabilising the industry, there is a need to focus on the long term viability of a rebate on insurance premiums where the current structure does not link the rebate

[7] Sitesh Bhojani, ACCC, cited from *Healthcover,* April-May 2003, 8.
[8] Graham Wright, Management Consultant, "A Response to the Australian Health Care Agreements series", *Australian Health Review*, Vol 26, No 1, 2003, 2.

directly back into the health care system, or distorts the product, or the community's perception about the product. An ideal opportunity (and a responsibility) exists for Government as a significant funder, to use whatever levers it has to improve it structurally. A number of options are proposed in this submission for consideration (section 5.2-5.3).

While there is debate about the costs and benefits of the 30% rebate, as long as current government policy of limiting access to health care services through tight budgetary constraints continues, it is important that those who are disadvantaged and elderly, those with chronic illnesses such as mental illness and cancer, and low income earners with children who opt for top up private health insurance for fear of inadequate access, must be assisted to access health care (public or private). Because of the nature of health care including its centrality to human life and its integral relationship with human dignity CHA believes there are compelling social policy reasons for supporting the general thrust of the 30% rebate.

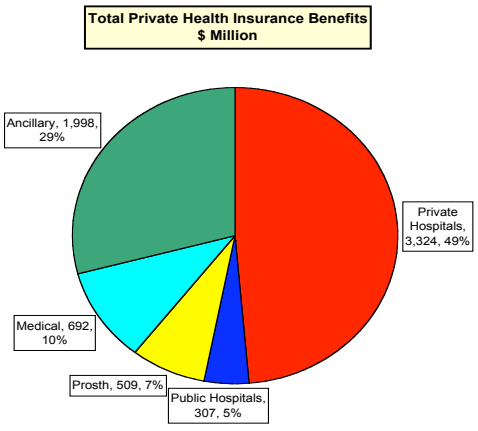
While the government appears resistant to modifying its general policy support for the 30% rebate and with some very good reason, some structural reform is suggested for consideration. A number of options for reform of the 30% rebate arrangements are available to government through the taxation system and government budgetary processes.

5.2 Ancillary Rebate Reform Options

CHA contends that ancillary insurance should be excluded from the scope of the 30% rebate arrangements, with its subsidy component of around $500 million per annum transferred to restored targeted programs. [ToR (d) (ii)]

If the purpose of the rebate was to shift inpatient demand from the public sector to the private sector, a subsidy for ancillary cover does not meet this goal. It contributes nothing towards hospital care. Deeble claims only about 40% of the $2.13 billion supported hospital service use that may provide future public offsets. The remainder went to ancillary services, upgraded insurance products, reducing out of pocket costs of already insured people.[9]

Chart 1: Total Private Health Insurance Benefits (derived from March 2003 PHIAC data)



[9] John Deeble, "The private health insurance rebate", Report to State and Territory Health Ministers, National Centre for Epidemiology and Population Health, ANU, January 2003.

Private health insurance benefits that are directed towards hospital costs have eroded relative to those benefits directed to ancillary products and doctors gaps since the introduction of the 30% rebate. At the same time, hospitals have been experiencing increasing cost pressures as they strive to meet the health care needs of patients. While it has been suggested that the primary care private health insurance product would be administered quite separately from existing private health insurance products, it is difficult to comprehend how this could be maintained in a health policy environment that is seeking to achieve better integration of preventive, primary, acute and community care at all levels of policy making.

Chart 2: Private Health Insurance Benefits Directed to Hospitals, Ancillary, Prostheses, Medical Products (derived from March 2003 PHIAC data)

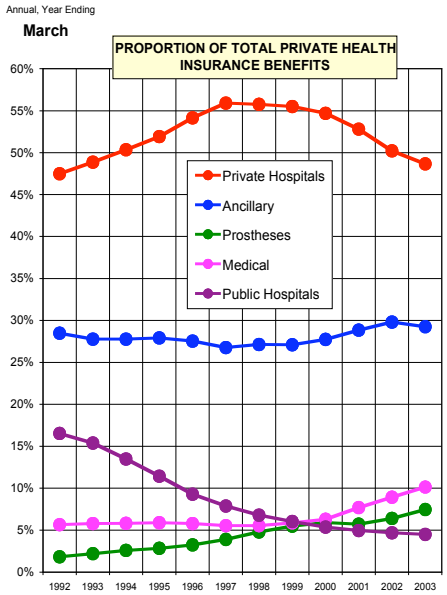
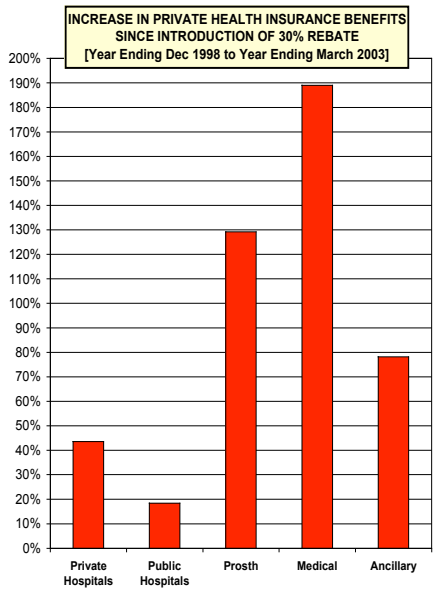


Chart 3: Increase in Private Health Insurance Benefits directed to hospitals, prostheses, medical and ancillary (derived from March 2003 PHIAC data)



The inclusion of ancillaries in the 30% rebate arrangement instils some stark distributional anomalies. It is difficult to argue that the 'simplicity' or 'promoting the product' reasons that presumably underpinned this decision outweigh equity issues. The earlier discussion regarding oral health are further highlighted in the context of the 30% rebate on ancillary insurance. With a significant proportion of this benefit going towards private dental care it exacerbates maldistribution between private dental care and poorly resourced public dental care. The subsidy for public dental care for adults is approximately $177 million each year, while the private health insurance rebate is approximately $316-345 million per year. Higher income adults using private dental insurance and dental care receive nearly five times the subsidy received by aged pensioners seeking public dental care.[10] [ToR (d) (i)+(ii)]

There are a number of program areas that would benefit from redistribution of savings achieved through removal of ancillary products from the scope of the 30% rebate. The savings could be redirected through the AHCAs or MBS (arguably the most systematic component of the Australian health care system) to services currently experiencing viability problems such as: [ToR (d) (i)+(ii)]

- mental health services particularly improving access to community care.
- oncology and cancer services with specific regard to pharmaceutical costs.
- palliative care services.
- rehabilitation, transitional and respite services.
- patients with significant co-morbidities affecting lengths of stay.
- HIV and AIDS services.
- drug and Alcohol rehabilitation services.
- Aboriginal health care services.
- dental care.

Recommendation 4: Remove ancillary private health insurance products from the scope of the 30% rebate arrangements and direct funds to targeted areas in the MBS or the AHCAs.

5.3 30% Rebate Reform Options

The Government through the taxation system also has at its disposal a number of options for instilling equity into the 30% rebate arrangement while at the same time ensuring that private health insurance remains affordable and sustainable, thus remaining supportive of the current government policy of maximising choice within the Australian health care system.

A number of reforms of the existing 30% rebate arrangement may even increase private health insurance take-up. These proposals have previously been submitted to government in various CHA submissions: [ToR (d) (ii)]

- Increase the rebate to say 40% for low income earners and the elderly, and reduce the rebate to say 0% for high income earners so that its impact is more progressive rather than regressive. This would be designed to capture high income earners who may be subscribing to low cost private health insurance products for the sole purpose of avoiding the Medicare levy surcharge contribution.

[10] John Spencer, "What options do we have for organising, providing and funding better dental care?", Australian Health Policy Institute, Professor of Social and Preventive Dentistry, Adelaide University, cited in *Healthcover* April-May 2003, 41.

- The Medicare levy surcharge for high income earners not subscribing to private health insurance (1%) could be increased to a level that is more commensurate with the cost of private health insurance thus providing a real incentive for its uptake (to say 2-3%). This additional revenue should help cover the cost of the 30% rebate and free up revenue for the health system generally. The argument is not about removing funding from the health system. Any revenues from restructuring of the rebate should remain in the health system.

- The current system of income tax disincentives for those not holding private health insurance could be extended to capture a higher proportion of middle to high income earners by decreasing the point at which the threshold takes effect.

- Complementary policy may be required to monitor and regulate the provision of private health insurance to ensure quality and cost-effective health insurance products and to reduce the future risk of coverage of questionable items such as occurred with public subsidy for the purchase of running shoes.

- Medical gap insurance over schedule fees is inflationary to private health insurance shifting resources to doctors incomes and not to additional services. Providing a rebate towards medical gap insurance that is up to 25% over the fee that the government deems fair, sends an inappropriate price signal. This anomaly costs $200 million per annum.

- Extension of gap insurance to out of hospital (doctor) services potentially threatens the universality of Medicare by introducing three tiers of health care and moving it much closer to the denounced USA model. Those who feel most compelled to take up private health insurance because of unknown risk are often young families with children and who have low incomes and who are not health care card concessions. They will be most disadvantaged by such a proposal. [ToR (c) (iv)]

  Not only that it increases the risk that the well-off will seek to abrogate their responsibilities to the less well off, pressuring governments to introduce an opt-out of Medicare scheme.

- Similarly suggestions that those who hold private health insurance should be obliged to use it rather than the public sector are fraught with dangers that they would increasingly pressure policy that enables them to opt-out of contributing towards Medicare.

- It is inappropriate that the administrative costs incurred by private health funds are subsidised through the 30% rebate. Administrative costs soak up 11% of private health insurance funds compared with Medicare administration costs of around 3%.

- Improve public hospitals' access to any benefit of increased private health insurance membership by promoting more realistic payment of hospital benefits by health funds to public hospitals for private inpatients.

- Increase incentives for the treatment of public patients in private hospitals, improving resource and capital utilisation of any spare capacity and better integration of public and private sectors.

- Consider reintroduction of subsidies being paid directly to private hospitals based on throughput and other performance outcomes, rather than directly to private health insurance products. This reduces both hospital charges and therefore the insurance required to cover them. Up until 1986-87 subsidies (of around 12.5%) were paid direct to private hospitals reducing up-front both their charges and the cost of insurance to cover them. They were removed as a budget saving but they commenced the exponential spiral in increased insurance costs (and thus decline in private health insurance membership). This option would mean the current rebate would become more consistent with the policy of universal health care, where government subsidies are delivered at the point of service delivery (as with the MBS and the PBS).

Recommendation 5: Consider a range of options of reform of the 30% rebate that would contribute to the improved equity and efficiency of private health insurance arrangements.

6.0 Moral Hazard and Copayments

6.1 Social Inequities

There is considerable moral hazard in the current system. Perceptions of risks change with insurance against them. People are more inclined to seek services, doctors are more inclined to recommend services when all costs are covered. Medicare ameliorates against this with fixed hospital budgets, and waiting lists and using clinical need as the primary criteria for access. But unreasonably long queues for those with chronic illness because of insufficient resources in the system is hardly efficient, beneficial for the economy in the longer term, or fair.

The levers for containing private health insurance costs are just not there when the primary funders (government and health funds) promote and advertise the major feature of the private insurance product as 'unrestricted access'. Add to that a proportion of members who perceive they were obliged to take up the product under lifetime health cover threats, and the hazard for uncontrolled utilisation, supply induced demand, cost increase, and run-away inflationary health care, abound.

The policy challenge is to introduce sensible price signals for most health consumers and most health episodes to combat moral hazard, while ensuring the universality of the system so that those in need can always access care. One area in need of redress is the proliferation of Health Care Cards, where asset tests may be indicated in an effort to support general practitioners who are finding it increasingly difficult to remain viable within a bulk-billing framework. Alternatively, extending the Health Care Card availability to those on incomes over $32,500 may provide some degree of compensation (or at least the prospect of bulk billing) to this increasingly disadvantaged group.

6.2 The Inequity of Copayments: Pharmaceutical Test Case

Price signals such as copayments implemented at the point of service are generally inequitable and discriminate against the most disadvantaged. The proposal to markedly increase the PBS copayment in the 2002 federal budget is an example of the copayment inequity. It is inequitable to heap more and more price signals on pharmaceuticals for example as was attempted in the 2002 Federal budget simply because PBS spending has been identified as fast growing; those most in need may be disadvantaged, and increasingly families with children will be pushed into a situation of disadvantage. It is arguable that Australia has not "hit the wall" in regard to national pharmaceutical spending. By international comparisons, Australia is a relatively modest spender on pharmaceuticals due in no small part to the cost effectiveness processes in place for PBS listing.

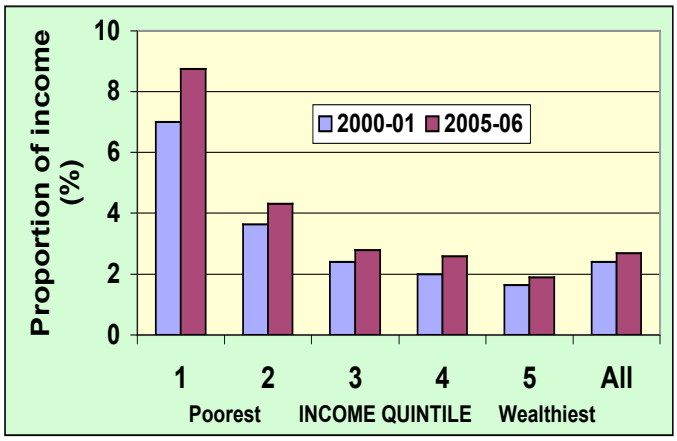
The highest income groups spend less than 2% of their incomes on pharmaceuticals while for low income groups who sit just outside the thresholds for concessional PBS access, pharmaceuticals claim 7% of family income, which may increase to nearly 9% within the next five years, as illustrated in Chart 5.[11] A recent study found that almost 20% of Australians reported not filling a prescription in the past year due to the

[11] Source, including Chart 5, from "Projecting pharmaceutical expenditure by patients and government" *NATSEM News*, Issue 18, February 2002.

copayment cost, yet these people are the ones who need it most as socio-economic status increases the risk of poor health in old age.[12]

Similarly in research into the impact of government fees and charges on people with low incomes, the disproportionate effect of increased PBS copayments, on low income families was reported.[13] In addition, the cost of over the counter medications not listed on the PBS caused considerable hardship for those on low incomes trying to prioritise health care ahead of telephone, electricity, food and school excursions. The effect was particularly hard felt by those with chronic illnesses and those requiring multiple medications. The research points to longer term economic inefficiencies caused by delayed access to medications.

Chart 4: Proportion of family income spent on PBS-subsidised drugs by general patients (NATSEM)



Patient copayments are not necessarily and universally "bad", but like everything a sense of balance is required. If the proposed sharp increase in PBS copayments are warranted by current budgetary circumstances, then the proposal should have ensured that the changes could be implemented in a manner that was not socially regressive. In short, the structure of income taxes and social security payments needed to be changed ***at the same time*** so that the higher copayments do not have the effect of pushing more of the tax burden onto lower income groups.

The issue of copayments needs to be revisited, and addressed across the whole spectrum of health care as copayments are not just an issue for the PBS alone. In any revisiting, it is extremely important that the social equity objective not be lost. The removal of a subsidy is the same, in effect, as the imposition of a tax. Just as new taxes are assessed for their impact and their equity, so too must any proposals for removal of subsidies.

This is not to say that copayments are unimportant in sending accurate price signals to consumers. Rather, the mechanism that was promulgated in the 2002-2003 Budget is a blunt instrument that treats all drugs as the same and all patients as the same, and which grossly

The Budget PBS cuts are a blunt instrument which potentially over-estimates savings, worsen health outcomes and increase other health and welfare costs.

[12] Kinnear, P "Ageing: will the real culprit please stand up?" *Australian Policy Online*, 31 May 2002.
[13] Helen Smallwood, Marilyn Webster, Valerie Ayers-Wearne, *User Pays. Who Pays?,* Good Shepherd Youth and Family Service, 2002, pp. 60-72, 90, 96.

over-estimates the "savings" from the PBS cuts because it seemingly denies that reducing pharmaceutical usage will potentially worsen health outcomes and increase other health and welfare system costs.

We should use the knowledge we have about these effects to protect vulnerable groups. The higher PBS copayments proposed in the Budget amount to a tax on the sick and the poor. They were not a balanced response to intergenerational pressures. And they are based on a spurious assumption: that we can cut funding now or raise taxes to pay for it. A more forward-thinking approach, which treats spending on dominant health therapies as an investment rather than a cost is suggested.

Recommendation 6: Reconsider current proposals before Parliament such as the introduction of increased copayments on pharmaceuticals due to their regressive impact on families with low incomes and children, and those with a chronic illness.

7.0 A Balanced View of Intergenerational Transfer and Equity Issues

CHA holds strongly to the view that Australia needs to develop a balanced view in relation to intergenerational equity issues. Social equity remains an issue of very considerable importance and concern. Good policy should simultaneously aim to address issues of social and intergenerational equity. It is inappropriate to consider health policy reforms such as that being proposed for Medicare in isolation to broader inter and intragenerational issues.

7.1 The Intergenerational Report

The 2002-2003 Budget was accompanied by the release of the first Intergenerational Report, as recommended by the 1996 National Commission of Audit. Five years in the making, the IGR was to highlight major long term challenges for the Federal Budget, including the effects of numeric and structural ageing – which precipitate both an increased demand for services and a diminished tax base from which to finance them.

However, the conclusions of the report are that despite a possible funding gap by the 2040s of some 5% of GDP ($87 billion in today's dollars) the Government is proposing no immediate strategies to address the cost of the gap between government services and available revenue. Government assurances don't equate with CHA's analysis of the future costs of long term care and the adequacy of retirement incomes.

A concern within the IGR is that Federal expenditures are considered in a vacuum, with no "scene setting" about what might be happening to State and Territory finances (not included in the index) or indeed to the private-public health and ageing financing mix. The critical issues of inter-personal versus inter-generational transfers get little airing, although it is the baby-busters and Generation X who will pay twice.

The IGR recommends key priorities that lack specific solution oriented analysis, for example:

- achieving budget balance over the economic cycle;
- maintaining an efficient, effective medical health system, with widespread participation in PHI;
- containing growth in the PBS;
- developing an affordable and effective residential aged care system that can accommodate the expected growth in the number of very old people (over 85);
- preserving a well-targeted social safety net that encourages working age people to find jobs and remain employed;
- encouraging mature age participation in the labour force; and
- maintaining a retirement incomes policy that encourages private saving for retirement and reduces future demand for the age pension.

7.2 Demographic Shifts

Over the past 30 years, the Australian population has gone through significant demographic change. By 2041 those aged 65 and over will represent 25% of the population compared with 8% 30 years ago and just over 12% currently based on ABS

statistics. This cohort of the population is expected to surge as a percentage of the total.[14]

Chart 5: Population by Age 1971 (ABS)

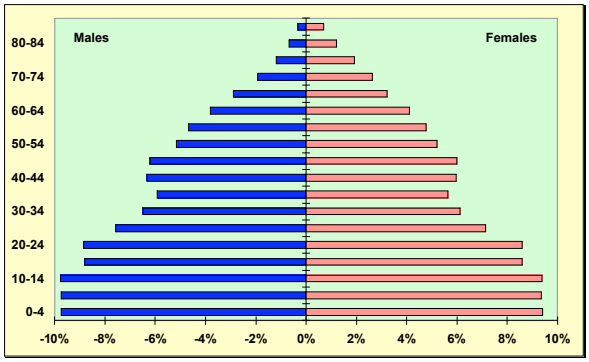


Chart 6: Population by Age 2001 (ABS)

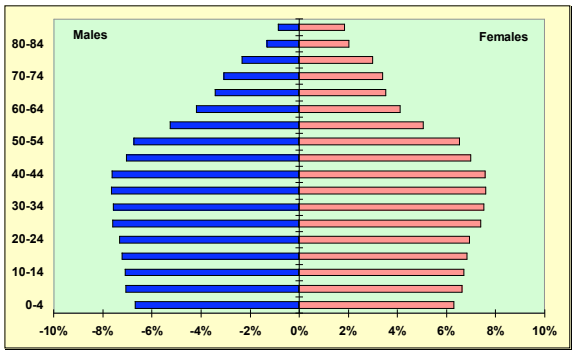
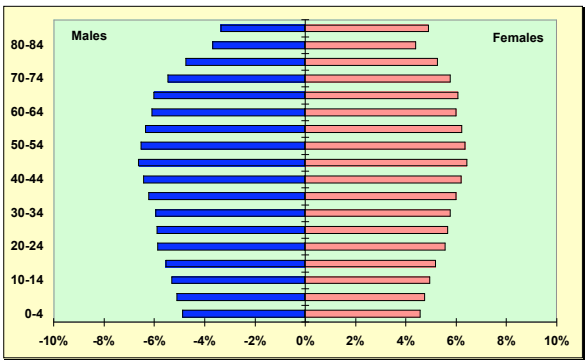


Chart 7: Population by Age 2041 (ABS)



The ageing of the Australian population will continue with increasing impacts on the need for and cost of health and aged care. Those aged 65 to 74 use almost twice as many medical services per capita as those aged 45-54 and over five times as many as those aged 10 to 14. In the case of hospital utilisation, the age differences are larger. Those aged 65 to 74 use three to four times as many patient days in hospital per capita as those aged 45-54 and some 17 times as many as those aged 5 to 14 while those aged 75+ almost eight times as many patient days in hospital per capita as those aged 45-54 and 40 times as many as those aged 5 to 14.

Rates of utilisation of both medical services and hospital services have changed over time. They will continue to change due to influences such as:

- Changing epidemiology in which chronic and degenerative conditions such as dementia, arthritis, osteoporosis and diabetes are heading for "epidemic" proportions.
- Changing health technologies which will save resources in some areas but make a claim for additional resources in other areas. Others have generated large cost increases. In budgetary terms the initial high costs of new health technologies are often spotlighted and this can be a very poor indicator of the unit costs and savings in later years to the broader community.
- Changing patient expectations whereby an older population will have deeper concern for access to health and aged care, influencing political processes and outcomes. There will be implications related to the willingness of people to

[14] Based on the ABS Series II projections published in *Population Projections*, Cat. No. 3222.0.

contribute to their own health and aged care costs, either through taxation, through private health insurance or through out-of-pocket contributions.

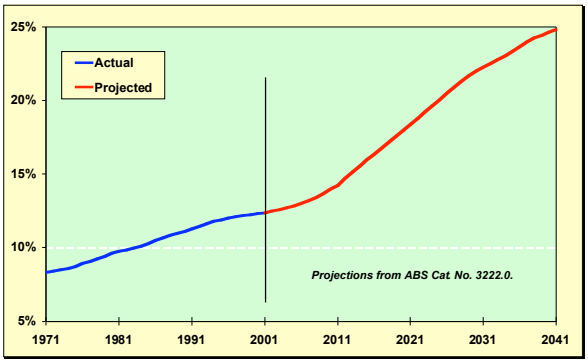
- Changing family and support structures whereby the number of single person households is projected to increase by over 70% from under 1.6 million in 1996 to over 2.7 million in 2021. For those aged 65 and over the increase is 90%. This has implications for the taxation system as families become less accessible as 'free' carers.

While we cannot easily foresee the full impact of these changes, there is nonetheless a substantial bundle of evidence for the proposition that the demographic change in prospect will generate higher demand for health and aged care than the demographic change in retrospect.

7.3 Less Dependence on Intergenerational Transfers

It will not be possible to meet increasing health care and retirement income expectations of the Australian community if we continue to rely on intergenerational transfers to the same extent as we do today. The crude dependency ratio (proportion of people over 65 relative to population) will double in the next four decades.

Chart 8: Persons Aged 65+ as a % of total population



NATSEM simulations of future trends in wealth inequality provide interesting projections for consideration in the equation also. Australia has an ageing population and the baby boomers are approaching retirement. There is a relationship between age and wealth. Wealth increases with age during working years but starts to reverse at retirement as draw down begins. Family wealth will increase by an average of 3.3% annually during the next 30 years; at that time the average family will be worth $446,000. But it won't be equal. From 2000-2010 wealth of the poor decreases and redistribution of wealth occurs among the wealthy. Between 2010-2030 wealth of the poor continues to decrease while redistribution among the wealthy is minimal. The ageing population and differing asset portfolios are cited as the main factors. Over the 30 year period the number of people aged 65+ will grow significantly and almost half of all family wealth will belong to households headed by a person aged 65+. It predicts home ownership will drop for young families and home ownership is the primary savings vehicle for Australians. While housing levels are projected to fall, investments that pay interest or provide income are forecast to almost double over the next 30 years and the primary beneficiaries are those aged 65+.[15]

[15] Simon Kelly, "Simulating Future Trends in Wealth Inequality", National Centre for Social and Economic Modelling, Paper presented at the 2002 Australian Conference of Economists, Adelaide, 3 October 2002.

8.0 Longer Term Structural Reform for Health and Aged Care[16]

8.1 Infrastructure Support For Health and Aged Care

People aged over 65 account for 12% of the Australian population, 30% of hospital admissions, and 43% of hospital bed day use.[17] Despite the constant blame game between the Commonwealth and the States over the existence (or not) of phantom aged care beds as a result of a severe capital crisis in the high care end of residential aged care, the fact remains, the elderly and frail are the losers in this game.

The key to a robust, efficient and effective health system is the development of a National Aged Care System encompassing improved integration of care services between the acute, residential, transitional, mental health and home and community care sectors. The current situation of a myriad of disparate programs leaves consumers at a loss in moving through the system and results in unnecessary duplication between programs, jurisdictions and providers, and piecemeal health and aged care. Strategies must be implemented to improve the continuity of care across programs and to address any cost shifting, service fragmentation and jurisdictional duplication measures that impede quality care.

Australia needs an holistic approach to achieve and maintain intergenerational equity. A limited and piecemeal strategy (trying to solve the issues to the extent that they arise in the Federal Budget but not addressing them elsewhere) is poor policy.

8.2 An Ageing Population – Problem or Opportunity?

In 40 years time, Australia will be a much wealthier nation than it is today. Even on the very conservative figures in the IGR, GDP per head of population will be over 80% higher than it is today. It is simply not plausible for anyone to suggest that a much wealthier Australia will be unable to offer all its citizens access to high quality health and aged care. To the extent that it does so will ultimately be a matter of choice reflected in social and economic policies adopted by the governments of the day.

CHA contends that we need a change in the national mindset. Australia ought to see the provision of high quality health and aged care as an opportunity and an investment, rather than as a problem. As part of that process of rethinking the issues, it is clearly important that policy makers and the population at large come to understand that older people are a valuable "resource" with the potential to make a strong positive contribution to society in many difference capacities (including as volunteers and carers).

The options for funding this investment are numerous. But at the heart of the decision is the trade-off between how much the individual user pays and maintaining an appropriate progressive taxation base that supports the long term health care infrastructure. The community's current concern for health care as the 'Number 1'

[16] Most of the contents of this section have previously been submitted by CHA to the House of Representatives Standing Committee on Ageing, "Strategies to address the ageing of the Australian population over the next 40 years", November 2002, and the Senate Economics References Committee Inquiry into the Structure and Distributive Effects of the Australian Taxation System, April 2003.
[17] Anna Howe, 2002.

issue as widely reported in polling, should be considered alongside recent research showing the community's increasing preference for taxation in exchange for social spending.[18] While there is still a gap between those who favour tax cuts and those who favour spending more on social services, the gap is closing. According to this research, from 1987 to 2001, the proportion of Australians favouring spending more on social services more than doubled from 14% to 30%. However, during the same period, there was a 23% decline in the proportion of Australians favouring reduced taxes. By the end of 2001, only 42% preferred lower taxes, with 30% supporting more social spending, and 29% saying 'it depends'. This suggests that if governments are open to it, there is room to move in terms of not giving tax cuts in exchange for user pays reforms, but instead directing increased funding to publicly funded health care, delivered either in the public sector or the private sector.

Some key issues for consideration in this context (previously detailed in CHA submissions to the House of Representative Ageing Inquiry and the Senate Economics Reference Committee Inquiry into the Structure and Distributive Effects of the Australian Taxation System), are:

- Workforce participation by older Australians
- Superannuation options
- Health savings accounts as a complement and not a replacement to Medicare and Private Health Insurance
- Social insurance scheme to fund long term aged care
- An Aged Care Benefits Schedule

Recommendation 7: Consider a range of reforms aimed at increasing older persons' participation in the workforce, reforming taxation on superannuation, increasing superannuation guarantee level, establishing long term health and aged care savings schemes, and introducing an entitlement based aged care benefits schedule, for the purpose of increasing options for future health care funding.

[18] Shaun Wilson & Trevor Breusch, 'Taxes and Social Spending; The Shifting Demands of the Australian Public', *Australian Journal of Social Issues*, February 2003.

9.0 Inquiry Terms of Reference

On 15 May 2003 the Senate agreed that a Select Committee, to be known as the Select Committee on Medicare, be appointed to inquire into and report by 12 August 2003 on the following matters:

The access to and affordability of general practice under Medicare, with particular regard to:

(a) the impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk-billing practices;

(b) the impact of general practitioner shortages on patients' ability to access appropriate care in a timely manner,

(c) the likely impact on access, affordability and quality services for individuals, in the short- and longer-term, of the following Government-announced proposals:

  (i) incentives for free care from general practitioners limited to health care card holders or those beneath an income threshold,

  (ii) a change to bulk-billing arrangements to allow patient co-payment at point of services co-incidental with direct rebate reimbursement,

  (iii) a new safety net for concession cardholders only and its interaction with existing safety nets, and

  (iv) private health insurance for out-of-hospital out-of-pocket medical expenses; and

(d) alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular:

  (i) whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system,

  (ii) the implications of reallocating expenditure from changes to the private health insurance rebate, and

  (iii) alternative remuneration models that would satisfy medical practitioners but would not compromise the principle of universality which underlies Medicare.