CATHOLIC HEALTH AUSTRALIA

SENATE SELECT COMMITTEE ON MEDICARE

SUBMISSION ON MEDICAREPLUS PROPOSAL

19 DECEMBER 2003

19 December 2003

Jonathan Curtis
A/g Secretary
Senate Select Committee on Medicare
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CATHOLIC HEALTH AUSTRALIA

Dear Secretary

Catholic Health Australia previously made submissions to the Senate Select Committee on Medicare on 20 June and 10 July 2003. CHA welcomes the Committee's invitation to make a further submission in response to the Australian Government's revised Medicare reform proposal entitled MedicarePlus.

Inquiries about this and CHA's earlier submission are welcome and may be directed to:

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Information about CHA and the health, aged and community care services that it represents is provided at section 10.0 of this submission. CHA looks forward to the opportunity to give evidence to the Senate Select Committee on this important issue.

Yours sincerely

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The Catholic health, aged and community care sector

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1.1 What Are The Assumptions?

CHA understands from the Australian Government's MedicarePlus proposal that an assumption is being made that because of budgetary constraints, the poor and needy are being prioritised in the health care system by:

(a) providing them with a chance of an additional $5 entitlement each time they visit the GP and therefore a better chance of being bulkbilled.

(b) providing a safety net guarding against catastrophic outlays only after $500 has been expended in one year ($1000 for high income earners).

In putting forward the MedicarePlus package the Australian Government appears to be facing some perceptions about the future sustainability of Medicare as an entitlement program in an ageing, high technology driven society. CHA submits that it is difficult to argue about budgetary constraints with the current surplus running in the order of $4 billion.

Some of the rhetoric does not match the reality of these proposed reforms. This package does not strengthen Medicare as a universal entitlement, rather it enhances the safety net provisions for people clocking up the medical bills that are the result of the chronic underfunding of the federal Medicare Benefits Schedule.

It also confirms that the costs of medical practice are outstripping the Australian Government's willingness to properly cover a visit to the doctor for everyone.

It signals the Australian Government's preference for well-off people to pay more at the point of service so a defined group (those with concession cards, and children under 16) may attract an additional $5 per visit Medicare insurance entitlement and thus have a slightly better chance of being bulkbilled.

There appears to be some major assumptions underpinning the MedicarePlus package – firstly, that many patients will pay more to see a GP. Only concession card holders and young children are the targets for bulkbilling. In other words the Government is content that nearly half of all GP patients can hold little hope of being bulkbilled. They will have to make the decision whether each visit to the GP is that important. They will lose the security of potentially being bulkbilled. In the mind of the Australian Government this is obviously acceptable public policy.

It remains to be seen whether such a package builds a fairer system than that which Medicare originally envisaged.

Secondly, in offering $5 extra for every concession cardholder and child under 16 years of age who is bulkbilled (around 60 percent of consultations), it has to be assumed that for doctors to meet their practice costs the other 40 per cent of patients will be charged

more. Such an increase will impact most on those on low to middle incomes who just miss out on concession card eligibility. In terms of the value of the safety net, these people would be unlikely to see the value of spending $500 (or $1000 if they are ineligible for Family Tax Benefit (A)) out of their pocket on health care costs before they begin to get a look at what a safety net might do for them. The fairness of the proposed system at this point becomes very questionable. The increasing copayment that these people will face each time they visit the doctor should be of critical concern. The cashflow implications for the family budget on low to middle incomes will be significant.

1.2 The Impact On Low To Middle Income Earners and Those With Chronic Illnesses With No Concession Card

In each iteration of the Australian Government's Medicare reform package, there appears to have been a failure to understand the extent of the impact of copayments on low to middle income families, and generally for anyone who has to find increasing copayments each time they visit their GP. The impact will be hardest felt by those with chronic illnesses and multiple conditions.

Firstly, GPs will only be able to sustain bulkbilling at its current rate of remuneration by seeing more patients for shorter consultations. The potential impact on quality care is obvious.

Secondly, people on low to average incomes will struggle to meet the cash flow demands which come when GP fees need to be paid. The safety net compensation will only flow once outlays of $500 (or $1000 if ineligible for FBT (A)) are reached and even then only when further medical bills arrive. The potential impact on patients forgoing important treatments is obvious.

Thirdly, there are people with concession cards who have better means than average working families. The claim by both groups to affordable and certain health care are equal. Yet their opportunities to access care are not. When income levels determine capacity to access crucial human service the inequities are obvious.

Fourthly, clinical autonomy is threatened. The dynamic between doctor and patient can be complicated where fees are concerned. If a doctor considers it prudent to schedule a series of visits for a particular patient, it can be troublesome if bulkbilling is not on offer and the patient is concerned about the expense. In these instances it is likely that the doctor will subsidise the inadequate bulkbilling benefit, use perceived high income earners to cross-subsidise, or the patient may choose to skip the appointments. Either way it undermines the importance of care plans based on clinical autonomy and professional judgements.

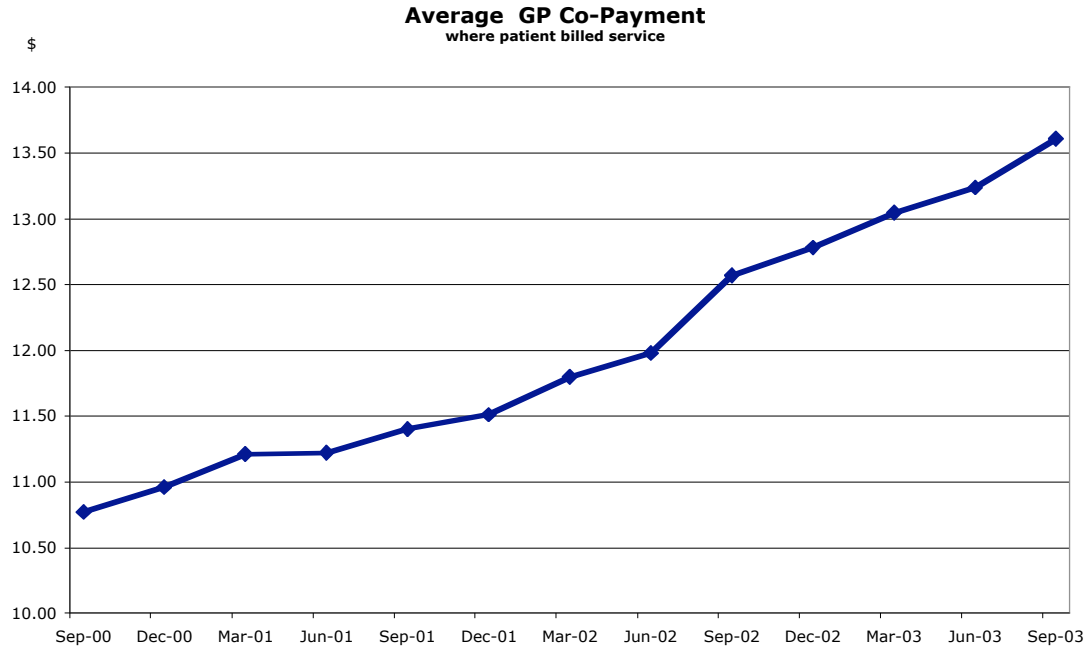
These points are supported by research undertaken by the Centre for Health Services and Policy Research in Canada on high users of health care. It found 4.2 percent of the studied population accounted for 17.5 percent of visits to GPs, 30.2 percent of visits to specialists, 36.3 percent of hospitalisations and 63.5 percent of all hospital days. Almost half of these high users were aged 60 or over, but age was not the primary cause of high use. This group bears an enormous burden of illness with multiple conditions and commonly with a combination of chronic physical and mental conditions. Over 80 percent

of high users had at least six different types of illness, and almost one-third had ten or more illnesses.[1]

The startling implication of such research for Australian policy makers to consider is that any policy instruments that might be used to deter use and reduce health cost outlays, such as user pays copayments for GP services will hit this group very hard. Rather than resulting in cost savings, these high users would be forced into the health system somewhere, and according to the analysis in this study, 'if they are denied care at an early stage because they cannot afford to pay, they are liable to incur greater overall costs by entering the system later, in a condition more likely to require expensive acute care.'[2] Faced with the prospect of copayments of $500 (or $1000) (on top of pharmaceutical copayments) before any relief is obtained, may be just the deterrence for patients that Treasury is seeking. It does not produce better health outcomes.

In reality the government's proposal is an across-the-board increase of just over $3 a GP consultation. This falls well short of the recognised costs of medical practice determined through the Relative Value Study of Medicare Rebates jointly undertaken by the Australian Government and the AMA. Thus the new safety nets are being proposed because the real costs are shifting to patients and such an initiative is assumed to alleviate some of the community concern about the impact of such cost shifting on the most vulnerable in the community.

This package does not increase Medicare's purchasing capacity in the doctor's surgery for everyone. Already the average out of pocket fee where a copayment is charged is over $13.50.



Source: Catholic Health Australia 2003 based on Medicare statistics which are available at: http://www.health.gov.au/haf/medstats/index.htm

[1] Reid RJ, Evans RG, Barer ML, Sheps S, Kerluke K, McGrail K, Hertzman C, Pagliccia N, "Conspicuous consumption: Characterizing high users of physician services in one Canadian province", *J Health Serv Res Policy*, Oct 2003; 8(4): 215-224.
[2] Reid RJ et al, *J Health Serv Res Policy*, Oct 2003; 8(4): 215-224.

The Australian Government needs to arrest the erosion of Medicare.

CHA contends that the Australian Government needs to add $10 to the MBS for each GP consultation, and index it properly into the future to stabilise the level of bulkbilling and the amount of copayments being imposed on those who are not bulkbilled.

1.3 Is MedicarePlus Really About Bulkbilling?

In analysing this policy proposal one could question whether the proposed reforms in any way are intended to support bulkbilling as has been claimed in the media. Medicare is about more than bulkbilling. It is public insurance. Its revenue is derived from a progressive taxation system whereby the well-off pay a proportionately higher percentage of their income towards its maintenance, than those who are less well-off. All Australians through their commitment to taxation are then entitled to the benefits of their public insurance based on their needs.

While Medicare as it was established was never intended to be about achieving 100 percent bulkbilling levels and a reasonable copayment from patients who could afford it was expected, the system should at least support bulkbilling to the level at which people on low to average incomes are not unduly discriminated against in their capacity to access essential health care services. Clearly it is difficult to prescribe an arbitrary number at which this occurs. But it is not difficult to appreciate that communities experiencing less than 40 percent rates of bulkbilling are at a significant disadvantage brought about by a series of Government policy failures that are interrelated – in the chronic underfunding of the MBS, workforce supply and maldistribution, the degrading infrastructure of rural communities, and factors contributing to escalating practice costs such as medical indemnity. The outcome of declining MBS remuneration and consequent bulkbilling levels that diminish to such a level that low to middle income earners are rarely if at all able to access it, is that the purchasing power of their public insurance and the value of their entitlement to Medicare is eroded.

1.4 A Place For Incentives To Increase Bulkbilling

CHA believes there is value in using incentives to improve geographical access to GPs and to improve access to bulkbilling more broadly. It may be more appropriate to use practice incentives and workforce strategies (such as those announced as part of these Medicare reforms) rather than differential MBS rebates to address workforce maldistribution. Some of the workforce strategies proposed in this package are welcomed in this regard. Any incentive such as a lump sum practice bonus should be linked in some way to encouraging GPs to achieve a realistic bulkbilling target. Any such target can really only be achieved by matching a proposed target with appropriate funding that helps to support GPs (particularly rural GPs) to attract locums, undertake regular training, and employ nurse practitioners.

It may be necessary to introduce a differential additional rebate in rural Australia only if its bulkbilling rates do not improve relative to metropolitan Australia in the future. The quantum of funding and commitment by the Australian Government to rural Australia more broadly will largely determine this. Differential rebates should be resisted if at all possible, as they potentially introduce unnecessary complexity and inequity into the

system. The majority of the Australian Government's proposed $5 bulkbilling initiative is likely to go to GPs in metropolitan areas who already bulkbill the majority of their services and currently attract a significantly higher proportion of Medicare benefits relative to their colleagues in rural and remote Australia.

The Government estimates around 62 percent of GP services are provided to children or Commonwealth concession cardholders. If there is no change to billing patterns GPs in metropolitan Australia will immediately receive additional Medicare income. In areas of low levels of bulkbilling that is being experienced in outer metropolitan and particularly in rural and regional Australian, there is absolutely no incentive to move towards bulkbilling as doctors' income would immediately decline if they did so; the copayments they impose already greatly exceed $5 – some as high as $35.

2.0 Options To Improve Medicare And MedicarePlus[3]

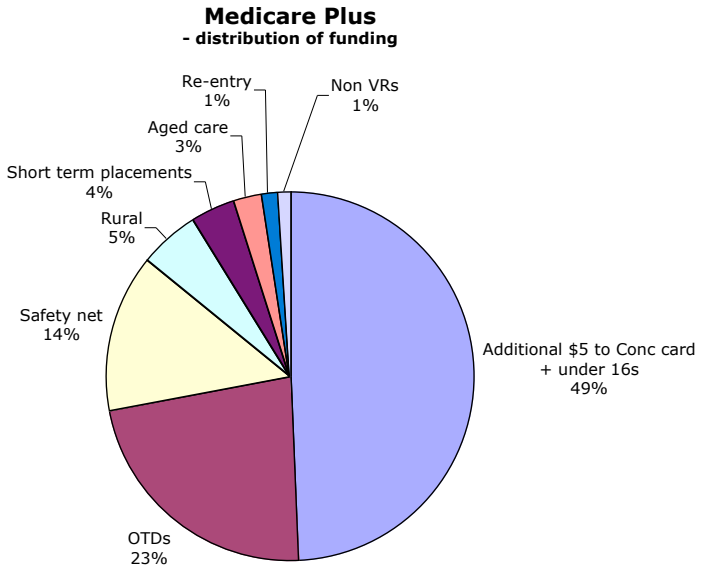
2.1 Is $5 Good Enough?

The proposed $5 limited to those with a concession card or aged under 16 at face value appears to continue to undervalue MBS services and the value of Medicare as a public insurance entitlement. As highlighted above, the existing average copayment in excess of $13.50 highlights that an additional $5 for those with a concession card or under 16 is unlikely to induce increased bulkbilling for those who do not fit these categories. Indeed the copayments that this group experiences are likely to increase.

CHA contends it is preferable to direct additional funds to the MBS rebate for GP consultations across the board. It is recommended that the Australian Government:

- Raise the GP consultation MBS rebate by **$10 for all consultations**.
- Properly **index the rebate** in the future to minimise further erosion of Medicare as an entitlement.

The Government's total MedicarePlus package of $2.4 billion covers a 3.5 year period – equating to under $700 million per year. The additional cost of increasing the rebate by $5 for bulkbilled services provided to concession card holders and under 16 year olds is $935.4 million over 3.5 years or $267.3 million per (full) year.[4]



[3] The following costings are sourced from Catholic Health Australia 2003 – these figures are based on statements in the MedicarePlus package and Medicare statistics which are available at: http://www.health.gov.au/haf/medstats/index.htm

[4] Based on statements in the MedicarePlus fact sheets – see http://www.health.gov.au/medicareplus/.

2.2 Extending The $5 Increase To All Bulkbilled Services

Extending the $5 increase to all bulkbilled services will cost $326.6 million (ie $5 x 96.9m services x 67.4% bulkbilled) or $59.3 million additional per year than in the Government package. This assumes the bulkbilling rate stabilises at 67 percent and the number of services does not decline further. As both are continuing to trend down and as a $5 increase is unlikely to induce many who have stopped bulkbilling to resume bulkbilling, the cost will actually be less.

2.3 Extending The $5 Increase To All GP Services

Extending the $5 increase to all GP services whether or not they are bulkbilled will cost $484.6 million (ie $5 x 96.9m services) or $217.3 million more per year than in the Government package. Again this assumes the number of services does not decline further.

2.4 The Cost Implications Of $10 For All GP Consultations

To provide a $10 increase for all GP consultations would cost around $969 million or $701.7 million more per year than the Government's current package.[5] CHA submits that this is a reasonable outlay in the current economic climate.

3.0 Compensation And Safety Nets

CHA has contended throughout the debate and in its previous submissions that these proposed Medicare reforms undermine the purchasing power of patients' public health insurance. The implementation of this Bill and the reforms are likely to impact most negatively on those people with low to average incomes (without a concession card) particularly if they have chronic illnesses. This is inequitable. Safety nets should only be implemented as a mechanism of last resort and to ameliorate against catastrophic levels of health care costs.

CHA cannot support the implementation of a safety net scheme as an alternative to Medicare.

CHA contends that the Australian Government has not yet made the case for why Australia as a society is not able to continue to fund an entitlement based public health insurance scheme (ie Medicare), particularly in the current economic environment of budgetary surplus.

[5] $10 increase would restore the GP MBS rebate to the same level as in 1996-97 when bulkbilling rates reached 80.6 percent - after allowing for increases in practice costs as calculated by the AMA - see http://www.ama.com.au/web.nsf/doc/WEEN-5NV349 at Appendix A.

3.1 Tenuous Nature Of Safety Nets

CHA acknowledges that compensation measures are tenuous and can erode in real terms over time. People on low incomes are vulnerable where compensation measures are instigated as safety nets.

In the interests of fiscal responsibility, a future federal budget could easily tighten eligibility for concession cards or family tax benefits. It is reported that over the last two years, one in five families eligible for low income concession cards lost access as the thresholds failed to keep pace with inflation and wages growth.

3.2 Administrative Complexity

CHA is concerned that the MedicarePlus package will be overly complex to manage by government and will place additional administrative burdens on Australian families. Further, the infrastructure and administrative processes necessary to implement the measures will be costly. The introduction of differing levels of safety net (concessional safety net; the FTB(A) safety net and the extended general safety net) will lead to increased complexity and high transaction costs. It will rely on a sophisticated link between the Australian Taxation Office, Centrelink and the Health Insurance Commission in terms of exchanging information and processing appropriate and accurate payments to Australian individuals and families. It will require additional monitoring and auditing across the board to ensure that the different levels of safety net are being administered correctly.

There is also likely to be increased responsibility placed on families to ensure that their family details are correctly recorded across various government bureaucracies. Families that currently do not have to report any changing family circumstances to government (for example if they are not in receipt of any government benefits) may find that they will have the new responsibility of notifying one or more government agencies about any changes in their family structure or circumstances.

It needs to be acknowledged that if the MedicarePlus changes are passed in their current form, considerable resources will need to be dedicated by government to administer the complexity of such a system and further, that the changes will mean that families will have more obligations in terms of advising government about any changes to their family circumstances and ensuring that all their family details and medical expenses are accurately recorded by government agencies.

Thus CHA supports an entitlement program approach as opposed to safety net structures as a more certain and sustainable structure to safeguard the interests of people on average to low incomes.

4.0 Options To Improve The MedicarePlus Safety Net Proposal – last resort

However, if the Parliament determines it will support this Bill and the limited remuneration changes to the MBS, CHA contends that measures must be taken to limit the potential negative consequences for those on low to average incomes who do not currently qualify for a concession card. The proposed safety net is certainly not sufficiently robust. A number of options are available, but it should be recognised that like the Government's MedicarePlus proposal, each of these options bring with them a level of administrative complexity as well as potential diminution of equity to that of a properly funded entitlement arrangement:

- Extend the safety net arrangements to cover 80 percent of health care costs above a threshold of $300.
- Extend the length of time for eligibility to the safety net threshold to say two years.
- Reduce the discrimination against low income single people in the proposed safety nets by lowering the threshold at which they are able to access the safety net arrangements.
- Reduce the discrimination against people in rural and remote Australia by lowering the threshold at which they are able to access the safety net arrangements.
- Combine the PBS and MBS safety nets into one single amount so as to minimise inadvertent perverse incentives that might favour one form of medical treatment over another.
- Expand the scope of eligibility for a concession card to encompass those people on low to average incomes, that is, those on less than average weekly earnings.

5.0 Private Health Insurance Issues

CHA welcomes the changes to the original proposal and Bill that now removes this provision.

6.0 Workforce Issues

The fairness of the package is also predicated on getting doctors, nurses and other health care workers where they are needed. The Australian Government's proposals for achieving this that in fact make up most of the funding package of MedicarePlus is welcomed for this reason. Some communities have no doctors, others have too many. Some low-income people do not get bulkbilled while better off people do. Until the supply of doctors, nurses and other health care workers reflects the actual health needs of the community, some people will have better opportunities to access health services than others.

CHA welcomes most of the workforce measures included in the MedicarePlus package.

6.1 More GP Training Places And Support For Practices And Supervisors

CHA welcomes this initiative which builds on the A Fairer Medicare proposal to provide an additional 150 GP training places per year to a total of 450 places. However it is essential that support is provided for all aspects of the rural placement including provision for any additional costs imposed on those taking rural placements such as ensuring appropriate accommodation, relocation costs, and assistance for those who incur additional workloads through taking on additional supervision responsibilities.

There is no provision in the proposal for similar assistance for allied health students and nurses on rural placements. Comprehensive rural primary care is not sustainable or viable unless there are coexisting health services that employ nurses and allied health professionals in addition to doctors.

6.2 More Graduate Doctors To Regional, Rural And Remote Areas

This proposal is welcomed although it is unclear whether it can be taken up. Funding is promised to compensate public hospitals that release junior doctors for 280 GP placements representing 70 doctors per year. Public hospitals are already experiencing workforce shortages so it is not clear how junior doctors can be released, without imposing further strains on those who remain and further reducing existing services in these public hospitals

6.3 Support For Practice Nurses

Nurses are essential to the delivery of primary health care in rural and regional Australia. MedicarePlus retains the previously announced grants for general practices to employ 457 practice nurses. The proposal has the potential to increase the economic viability of rural and remote general practices. However, it is not clear whether this proposal will be sufficient to attract nurses away from other areas of nursing which are equally experiencing workforce shortages, or whether it will increase numbers in the nursing workforce. Limited as it is, the proposal to enable restricted services provided by nurses working in a general practice to be paid through the MBS, is also welcome. While the package claims this measure will free up the GP time equivalent of up to 160 doctors, it

should not be assumed that this will translate into extra doctors; doctors may simply choose to reduce their unacceptably long hours of work.

6.4 Support For Procedural GPs

Procedural GPs (anaesthetics, obstetrics, surgery) in rural and regional Australia have been in decline in rural and regional Australia for a number of years due to: escalating medical indemnity costs; workforce shortages resulting in unavailability of locums; escalating time and financial costs associated with additional training requirements; changing role of public hospitals in rural and remote areas; and the general decline in the industries and populations of rural towns. The Government's proposal to reimburse GPs for some of their additional practice and professional development costs through the Practice Incentive Program will go some way towards assisting GPs who have retained more than 10 percent of their practice as procedural. The proposal will assist in the retention and continuing comprehensiveness of practice of some rural GPs. The quantum of funding is unlikely to attract additional procedural GPs back to areas where they have left.

6.5 Drawing On Qualified Doctors From Overseas

Overseas trained doctors are playing an increasingly prominent and important role in the delivery of GP and specialist medical services in rural and regional Australia. The Government's proposals would be expected to encourage more doctors from overseas and for them to remain in Australia for longer periods. The proposal for improved training and support programs for 725 FTE overseas trained doctors is welcome. It is imperative that this proposal translates into initiatives that make these individuals and their families welcome in local communities. However, it is important to ensure that this initiative does not impact negatively on developing countries.

6.6 Bonded Medical School Places

CHA is in agreement with groups such as the National Rural Health Alliance, in providing conditional support for bonded scholarships where students receive funds to assist them in undertaking a medical degree in exchange for a commitment to practice in a specified area for a specified time. With appropriate support and full disclosure by both parties this would seem reasonable. In the absence of financial or other support in exchange for bonding, there are a number of concerns about this policy.

6.7 Other Medical Workforce Measures

CHA supports proposals to extend the higher retention payments for GPs in rural and remote areas for a further four years. The proposed increased Medicare benefit for patients of GPs who are not vocationally registered from $17.85 to $25.70 if they work in areas of workforce shortage and were practising prior to 1996 is also welcome, although it is necessary to index the MBS appropriately across the board. The initiative to provide financial incentives and refresher courses for GPs and specialists to re-enter the workforce is also supported.

7.0 New Aged Care Benefit MBS Item

The addition of a new MBS item for comprehensive medical assessments for new and existing residents, attracting a rebate of around $140 is welcome. This initiative provides funding of up to $8,000 to a GP who provides services to aged care residents who do not have a regular doctor, including after hours and in an emergency, and who participates with the residential facility in quality improvement. The funding to Divisions of General Practice to establish local GP panels is also welcome.

8.0 Conclusion

CHA is concerned that the proposed reforms and the legislation supporting it, essentially diminish and erode the purchasing power of patients' public health insurance. The proposed reforms do not appear to value medical services to a level that would either halt the further demise of bulkbilling or to improve its current level. Instead, underpinning the multi-pronged approach of this reform and its predecessor are a number of measures that seem to be much more directed at breaking down a long-held Australian communitarian value. As an entitlement program and public health insurance program (albeit chronically underfunded) Medicare relies on community solidarity, sharing the risk, and an attitude that does not seek to not impose copayments that 'tax the sick'.

Clearly the status quo with regard to Medicare and the increasing copayments being incurred by patients when they visit the GP is not acceptable or equitable. The statistics that show high income metropolitan electorates have bulkbilling rates of 98 percent compared to rural and remote electorates that barely scrape 30 percent are ample evidence that successive governments have contributed to the diminution of Medicare as an entitlement program simply through neglect of indexation and inability to act on the findings of its own Relative Value Study.

MedicarePlus attempts to recognise some of the inequities of the system by offering safety nets, but a more substantial investment is needed to ensure everyone has an equal opportunity to access essential health care.

Ordinary people will still be confused why a more significant injection of funds into the MBS, which is the patients' insurance cover at the surgery, was not the centrepiece of the Australian Government's response to community concern about Medicare.

CHA calls on the Australian Government to immediately address the shortcomings of the MBS rebates and its indexation, rather than introducing complexity and administrative burden into the Medicare system through inadequate safety net arrangements.

CHA calls on the Senate to reject the direction of the Australian Government's MedicarePlus package and work with the government towards restoring the purchasing power of Medicare as an insurance product.

9.0 Additional Terms Of Reference

On 25 November 2003, the Senate referred the matters set out below to the Committee for inquiry and report:

(a) the Select Committee on Medicare, appointed by resolution of the Senate on 15 May 2003, be reappointed with the same powers and membership as previously agreed, except as otherwise provided by this resolution;

(b) the committee inquire into and report on the Government's 'Medicare plus' package including, but not limited to:

- the Government's proposed amendments to the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003,
- the Government's proposed increase to the Medicare rebate for concession cardholders and children under 16 years of age, and
- the Government's proposed workforce measures including the recruitment of overseas doctors;

(c) the committee have power to consider and use for its purposes the minutes of evidence and records of the select committee appointed on 15 May 2003; and

(d) the committee report by 11 February 2004.

10.0 Catholic Health Australia – The Sector

Catholic Health Australia was established in response to a sector wide process which aims to promote and strengthen the organised expression of the Catholic health ministry. The healing ministry of Christ is an integral part of the Church's mission. With a rich tradition of more than 160 years of commitment and service provision to the Australian community, the Catholic health sector is the largest provider group of non-government health, aged and community care services.

Under the authority of the Leaders and Owners of Catholic health, aged and health related community care services, diverse elements of the sector are working together as a community under a common shared vision to enhance the healing ministry of Christ.

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 the 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 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 rural and regional Australia, demonstrating its commitment to the delivery of services where they are needed irrespective of whether any or minimal return on investment is derived.

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 care, rehabilitation, diagnostics, preventative public health, medical and bioethics research institutes.

Services are provided in a number of settings, for example, residential, community care, in the home, the workplace, hospitals, medical clinics, hospices, correctional facilities, as well as for people who are homeless. In addition, services are provided in rural, provincial and metropolitan settings, in private facilities as well as on behalf of the public sector.

The Catholic Health Ministry – A Snapshot

- 135 owners of Catholic health, aged and health related community care services; 112 of which are members of CHA.
- 485 aged care services, 157 of which are in rural and regional Australia.
- 350 approved residential services.
- 17,000 approved residential aged care beds (32 percent of all operational religious residential places and 13 percent of all non-government places).
- 5,334 retirement and independent living units and serviced apartments.
- 4,417 Community Aged Care Packages representing 17 percent of all allocated packages.
- 4,729 Home and Community Care Services recipients.
- 7,900 beds in 59 hospitals; seven of them teaching hospitals and 17 located in rural and regional Australia. Twenty are publicly funded and 39 are privately funded and they represent around 13 percent of the Australian hospital system.
- around 30,000 people working in the sector.

Catholic Health Australia Incorporated is incorporated in the Australian Capital Territory under the Associations Incorporation Act 1991.