Public Hospitals Health and Medicare Alliance of Queensland

Submission to The Select Committee Inquiry in to Health Policy, Administration and Expenditure

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Introduction

The Public Hospitals Health and Medicare Alliance of Queensland (PHHAMAQ) thanks the Senate Select Committee for the opportunity to comment on the health policy, administration and expenditure. PHHAMAQ is a broad coalition of consumers, community groups, health service providers and trade unions who share a common concern for the future of the Australian health system. The Alliance was formed in early 1998. PHHAMAQ is a member of the national organisation the Australian Health Care Reform Alliance (AHCRA).

The purpose of this Alliance is to:

- Share information about issues of concern to Alliance members; and
- Raise awareness within the community and with all political parties about health matters.

National Commission of Audit as an Ideological Platform for Health Policy, Administration and Expenditure

In October, 2013, the federal Treasurer, Joe Hockey, and the Minister for Finance, Senator Mathias Cormann (2013), announced a National Commission of Audit to 'review and report on the performance, functions and roles of the Commonwealth government'. The National Commission of Audit (the audit commission) released two reports (2014a, 2014b) recommending significant cuts to spending on healthcare, education, unemployment benefits and pensions, aged care, child care, family payments and the new National Disability Insurance Scheme (NDIS).

Under its terms of reference, the Abbott government gave the audit commission clear instructions to recommend ways to achieve its ideological objectives of reducing the role and functions of government and to reach a surplus target of one per cent of GDP within the next ten years. Given the partisan membership of the audit commission[1] and the nature of its terms of reference, there was no possibility the reports would represent an independent assessment of the national finances. Less than two weeks after releasing the audit commission's reports, the Abbott Government brought down its 2014-5 budget. The budget has been the instrument for implementation of a number of the audit commission's recommendations on health spending or variants of them.

[1] The Abbott Government appointed Tony Shepherd to chair its audit commission. At the time Mr Shepherd was president of the Business Council of Australia (BCA), a position he had held since late 2011. He was also chairman of listed company, Transfield Services, between 2005 and October 2013. The other Commissioners also had connections with the BCA or the Liberal party.

This federal budget marks the beginning of a wide-ranging agenda to change Australia's health system through economic policy based on neo-liberal principles of small government and large private interests. An outdated ideology that finds its origins in the 1980s moves to dismantle the mixed economy and reduce the role of government informs the audit commission's reports and thus underpins the 2014 federal budget.

PHHAMAQ rejects the basic assumptions on the role of government put forward by the audit commission and the attempt to refashion the Australian economy and health system through the budget. PHHAMAQ believes government has a vital and effective role to play in the delivery of quality, cost effective health services.

Government provision of health care

PHHAMAQ believes healthcare based on clinical need is a human right and patient care must always take precedence over profits. PHHAMAQ is very concerned about the Abbott government's long-term health agenda signalled by the audit commission and its message that the current system is unsustainable. The audit commission's recommendations indicate the 2014 federal budget is a first step towards shifting the vast majority of people onto private health insurance where Medicare will become a government 'safety net' arrangement for the 'most' disadvantaged.

In Section 7.3 of its phase one report, the audit commission (2014a) states:

> Recent Productivity Commission projections suggest Commonwealth Government spending on health will rise from around 4 per cent of GDP in 2011-12 to 7 per cent in 2059-60. Health expenditure by State governments is projected to rise from around 2.5 per cent of GDP to almost 4 per cent of GDP over the same period. Other research projects similar trends.

Richardson (2014) has claimed that the unsustainability of government health expenditure in Australia is a myth that has been carefully nurtured to justify policies to transfer costs from government to the public. According to Richardson (2014)

> The fear that the rising share of GDP spent on health will harm the economy or our standard of living – reflected in numerous reports for the government, including the recent National Commission of Audit's – is probably a result of bad arithmetic. It's entirely possible for spending on health to rise more rapidly than GDP and for the amount of non-health GDP to continue to rise.

> If GDP growth per capita fell to the annual average of 1.4% per annum, which occurred between 1970 and 1990, then by 2050 per capita GDP would rise by 65%. And if health expenditures rose to the US level of 17.7%, there would still be a 50% increase in non-health GDP per capita.
>
> The unsustainability myth is created by focusing on percentages and not on the absolute level of resources available. Health spending probably will rise as a share of GDP, but the economy is flexible. In 1901, agriculture accounted for 19.5% of GDP; today it is 2%.
>
> The composition of GDP varies with technology and demand, and increasingly (as agriculture and now manufacturing, decline in percentage terms), services – including health services – have expanded.

Other eminent economists such as Saul Eslake, support Richardson. Eslake (quoted in Swann & Hunter, 2014) claims a modest rise in health spending was inevitable as Australians grew richer and older and that 'to call it unsustainable is probably an exaggeration'.

Duckett (2014) concurs. Far from having a health funding crisis, Australia has 'one of the best health systems in the world'. According to Duckett (quoted in Swann & Hunter, 2014) Australia has less than the OECD average on health spending per capita and has better than the OECD average on life expectancy. So in reality Australia is in 'the healthcare system sweet spot'.

As Richardson (2014) has also pointed out, the real problem seems to be 'a dislike of communal sharing even when it is to alleviate the financial burden of those already disadvantaged by illness'.

International comparisons indicate that Australia is in no particular peril in this area. Australia's health to GDP ratio was equal to the OECD median in both 2001 and 2006 at 7.7% and 8.0% respectively. In 2011, it was still around the OECD median (9.1% compared with the OECD median of 9.0%). In 2011, Australia spent a similar proportion of GDP on health as Spain and the United Kingdom, a higher proportion than Sweden, Norway and Ireland, and a lower proportion than New Zealand, Canada and France (AIHW, 2013 p.26).

In our view, creating a crisis in health spending provides the federal government with the impetus to promote and implement its agenda to privatise the health sector.

In Section 7.3 of its report the audit commission (2014a) makes this quite clear.

> Putting health care on a sustainable footing will require reforms to make the system more efficient and competitive. The supply of health services must

> increase in line with growth in demand and improvements in productivity are a natural way of ensuring this. More deregulated and competitive markets, with appropriate safeguards, have the greatest potential to improve the sector's competitiveness and productivity.

Various state governments have experimented with privatisation of hospitals and it has been unsuccessful. The Queensland government recently withdrew its plans to privatize a number of public hospitals following a major advertising campaign by the Queensland Nurses Union, which pointed out the financial and clinical risks involved – risks confirmed by KPMG reviews of the Queensland Government's plans.

In various States, governments have had to resume the running of public hospitals or bail them out after private sector failures (see for example the unsuccessful privatisation of Modbury Public Hospital in South Australia, Robina Hospital in Queensland, Port Macquarie Hospital in New South Wales and Mildura Base Hospital).

Combined with its general view on the role of government, safety nets and increased private payments, the audit commission's proposals would eventually dismantle Australia's public hospital system and, as evident in places like the USA that run privately-dominated hospital systems, lead to massive financial risk for most low and middle income Australians.

The audit commission's other key health/Medicare recommendations make it clear that the audit commission wants to force increasing numbers of people into private health insurance and out of a national, government-run social insurance arrangement and eventually leave free-at-the-point-of-service hospital care as a charitable system for the "most" disadvantaged. This is in keeping with its general undervaluing of government programs.

To commence this process, the audit commission recommends a number of initial changes to reduce spending on healthcare and hospitals and force high income earners into private health insurance.

Section 7.3 of the audit commission's phase one report (2014a) calls for a broader, long-term review (encapsulated in Recommendation 18) with a heavy emphasis on privatization ideas such as a universal health insurance arrangement. Such a scheme would make health insurance mandatory for all Australians. The Commonwealth would pay premiums for low income and high risk groups and also pay for the health insurance of all children. It would be compulsory for people on higher incomes to take out private health insurance.

Medicare would remain as the default insurer for those on lower incomes, with their premiums paid by government direct to Medicare. People on low incomes could alternatively choose a private health insurer, with their premiums still paid by the government.

PHHMAQ strongly opposes this type of policy change. Medicare provides a common good for the benefit of all Australians.

PHHAMAQ seeks to redress the inequity and injustice in the delivery of health care that are undermining Australia as a nation by paying particular attention to:

- Closing the gap in life expectancy and health outcomes from indigenous Australians;
- Meeting the health needs of those with special needs such as people with disabilities and;
- Addressing the social determinants of health that negatively impact on the health status of individuals and communities.

A universal health insurance system such as Medicare is the fairest way of meeting people's needs while containing costs.

Medicare Co-Payment and Health Funding

PHHAMAQ calls on the Australian Senate to continue rejecting the proposed Medicare co-payment of $7. Although health experts[2] have systematically condemned the proposal, the budget introduces a co-payment of $7 for each General Practitioner (GP) visit and any out-of-hospital pathology and X-rays.

The existing rebate for these services will be reduced by $5 but GPs will be able to recoup $7 by levying a patient charge. The co-payment aims to generate savings by acting as a deterrent for GP use based on the premise that if people have to pay, they will only go to the GP when it is absolutely necessary. After the first 10 services, a 'safety net' will apply for pensioners and card holders.

The federal government well knows the effects of this initiative, but has decided to proceed regardless. Australians already have high out-of-pocket expenses[3] for medical care by world standards and many avoid or delay medical care due to cost. Earlier this year, the Senate Select Committee into the Abbott Government's Commission of Audit received written submissions and heard evidence that co-payments may lead to cost shifting rather than cost saving. Indeed Professor Stephen Duckett told this Committee that if only one in four or

[2] See for example the recent publications and commentary of Professor Stephen Duckett and Dr Anne-Marie Boxall.

[3] The out-of-pocket healthcare costs in Australia have risen at much faster rates than most other countries, and this has already placed a cost-barrier in the path of low-income groups. Overall out-of-pocket costs amounted to 17.3% of total health expenditure in Australia in 2011- 2012 (AIHW, 2013, p. 32).

one in five people who might otherwise have gone to a doctor decides to go to a hospital emergency department then there are no savings for the Commonwealth government at all and substantially increased costs for state governments through further pressure on the public hospital system (Duckett, 2014).

Studies have found that over a third (36%) of Australians with chronic conditions reported problems with accessing healthcare due to cost; 17% of Australians had "skipped a medical treatment, test or follow-up recommended by a doctor, because of cost"; and 35% of Australians reported not accessing dental treatment due to its cost. When people are not able to access appropriate care, their condition can become more serious which results in increased expenses both to them and to the community as a whole (Doggett, 2009).

PHHAMAQ is concerned that the co-payment will:

- force more people to attend emergency departments;
- reduce use of GP visits for preventive services such as immunisations and cancer screenings;
- be an unfair burden on the poorest and sickest members of the community who are most likely to defer visits to the GP because of cost;
- cause those who do not qualify for the safety net to miss out on care.

The federal government predicts co-payments will produce budget savings of over $1 billion that will go towards a medical research fund. Therefore the Treasurer and Finance Minister's rhetoric that the health system is unsustainable falls flat because the co-payment will not even go towards funding the system.

The Treasurer claims the research fund will help to discover the 'cures of the future'. Meanwhile, the sickest and most vulnerable members of the community will fund the research, not the large medical and pharmaceutical interests who will also benefit from the outcomes. This places academics in a position where they must rely on funding from the sickest Australians in order to pursue medical research, a cynical move that speaks volumes for this government's disregard for both sectors of the community.

The budget enables States to charge $7 for hospital emergency department visits, however, we note in Queensland, Campbell Newman has ruled out his possibility (at least for now). It is therefore likely that those who cannot afford the co-payments will seek treatment at emergency departments and place further pressure on the acute sector. The elderly and those with chronic disease will be the most affected by co-payments and are likely to delay or avoid seeking care. However, instead of introducing systems that could improve their access to healthcare, this government has created barriers. The most vulnerable members of society will feel the impact of this short-term savings initiative.

Role for Consumers

Despite the Treasurer and Finance Minister's assurances, the 2014 budget fails to build a smarter health system. Some patients may need a doctor on occasions, but many live with chronic disease. The budget is a missed opportunity to design a more efficient payment and reimbursement mechanism to:

- promote the delivery of preventive services;
- develop improvements in health literacy, and infrastructure;
- support evidence based practices that engage patients; and
- provide consumers with the tools to inform healthier lifestyle decisions.

The budget also fails to provide funding to prepare the health workforce for new roles that serve patients in a world of expanding innovations, knowledge and change.

It is simplistic and short-sighted of this Government so unashamedly to design a co-payment system that deliberately discourages patients from seeing their doctor while failing to recognise that patients need help in understanding their own role in self management of their health conditions.

Numerous studies[4] demonstrate the critical role patient engagement plays in the components of successful disease management. The very nature of chronic disease demands active patient participation such as daily choices on lifestyle, exercise and nutrition. The budget fails to demonstrate a commitment to partnering with consumers and carers in all parts of the health system from their own care through to policy-making and co-designing systems and services. Consumers can bolster disease prevention and management efforts through self-management and improved health literacy.

In the context of the health system, patients present a critical, untapped resource for exploring health reform that is both efficient and provides value for money. Sadly, this budget not only misses the opportunities in this area, it further demeans patients by making it harder for them to access the system.

Public Hospital Funding

Another area of particular concern in the 2014-15 budget is the federal government's retreat from the agreed funding arrangements with the State and Territory governments under the National Health Reform Agreement. The federal government is urging the States and territories to drive productivity and efficiency improvements in public hospitals to rein

[4] See for example the work of Kennedy, Rogers, & Bowers (2007), Jordan, Briggs, Brand, & Osborne (2008) and Coulter, & Ellins (2007).

in expenditure growth. Commonwealth funding to public hospitals will increase every year but from 2017-18 the government will introduce revised funding arrangements that remove funding guarantees.

These measures will achieve cumulative savings to the federal budget of over $80 billion by 2024-25 – but the $80 billion represents funding withdrawn from the states. The federal government will also reduce or terminate some Commonwealth payments including:

- National Partnership Agreements on Preventive Health;
- Improving Public Hospital Services; and
- Certain concessions for pensioners and seniors card holders.

The States will be expected to continue contributing to these arrangements at their own expense. This unanticipated move has angered most Premiers and will no doubt be the subject of further detailed negotiations. While the Queensland Premier is decrying this action by the federal government it is important to remember that his government has been responsible for unprecedented job and service cuts in Queensland Health.

The following table indicates the total number of positions that have been cut from Queensland Health since September, 2012. These figures are accurate as of 11 September, 2014 and are based on information supplied to the QNU (a member of PHHAMAQ) from Queensland Health. Despite orders from the Queensland Industrial Relations Commission, the QNU has had to make numerous Right To Information (RTI) requests to obtain correct data on the number of abolished positions. The QNU expects to identify more job losses once all data is analysed.

Stream	**Number of positions cut**
Admin	1001.27
Building/Engineering	44.84
Dental	7.00
Executive	49.00
Health Professional	685.31
Medical	74.92
Nursing and midwifery	1796.05
Operational	1140.19
Professional	20.37
Technical	2.00
State Total	**4820.95**

PHHAMAQ also notes significant job loss at the federal level due to budget cuts.

Health Portfolio Average Staffing Level (ASL) by agency

Agency	2013-14 ASL as reported at the 2014-15 Budget	2014-15 ASL	Change
Department of Health	3,731	3,405	-326
Australian Commission on Safety and Quality in Health Care	68	77	9
Australian Institute of Health and Welfare	306	294	-12
Australian National Preventive Health Agency	33	0	-33
Australian Organ and Tissue Donation and Transplantation Authority	28	28	0
Australian Radiation Protection and Nuclear Safety Agency	135	130	-5
Australian Sports Anti-Doping Authority	78	62	-16
Australian Sports Commission (includes Australian Sports Foundation Limited)	642	505	-137
Cancer Australia	66	72	6
Food Standards Australia and New Zealand	115	107	-8
General Practice Education and Training Limited	62	31	-32
Health Workforce Australia	129	0	-129
Independent Hospital Pricing Authority	55	59	4
National Blood Authority	54	53	-1
National Health and Medical Research Council	217	208	-9
National Health Funding Body	19	19	0
National Health Performance Authority	53	54	1
National Mental Health Commission	13	13	0
Private Health Insurance Administration Council	33	32	-1
Private Health Insurance Ombudsman	12	12	0
Professional Services Review	17	17	0
Total	**5,866**	**5,177**	**-689**

Source: Australian Government (2014) 2014-15 Budget Paper 4, Table 2.2 Average Staffing Table

The same small government agenda that drives the Queensland LNP government also propels the Abbott Coalition government, just as their respective Commissions of Audit provide the ideological platform for their budget cuts.

PHHAMAQ opposes the privatisation of public health services because it fundamentally undermines universal health care and shifts risk and costs to individuals and families. The provision of private health services is and should only ever be complementary to the maintenance of a viable and effective public health system.

End of Medicare Locals

From 1 July 2015, the Government will establish new Primary Health Networks with a smaller number of local networks replacing Medicare Locals. The Primary Health Networks will have General Practice as the cornerstone and be clinically focused and responsible for ensuring that services across the primary, community and specialist sectors work together in patients' interests.

The government will also explore models of primary health care funding and coordinated delivery, including partnerships with private insurers. PHHAMAQ believes primary and preventive health strategies are the foundation of an effective health care system. We support and promote early diagnosis and treatment to minimise the development of chronic disease and supports individuals to optimise their own health.

We question a greater role in primary health care for private insurers. We are aware that in recent years, some insurers have been testing opportunities to expand their involvement in primary care, through measures to reduce hospital admissions (and therefore, costs) by keeping their members healthier. Insurers are currently restricted in their offerings in primary care (Wells, 2014).

PHHAMAQ does not support any measures to remove this restriction as private insurance for the GP fee gap would likely put upward pressure on GP fees overall, thus making it more expensive for those without private coverage.

Conclusion

PHHAMAQ believes that healthy citizens are the most valuable resource of any society. Our health system must be genuinely centred on the needs of individuals and families.

The major challenge for supporters of Medicare and our current health system are the market-based, privatisation values underpinning the audit commission's recommendations and the Abbott Government's 2014-2015 budget that has already sought to implement a number of its proposals, such as hospital funding cuts and a GP co-payment. We believe Medicare provides a common good for the benefit of all Australians and the federal government must continue to fund health care services that provide equity of access and outcomes.

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