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Fair health funding

Submission to House of Representatives Standing Committee on Health and Ageing Inquiry into Health Funding

Introduction

The Australian Council of Social Service (ACOSS) has a keen and long-standing interest in the equity of the health system.

The way in which health systems are funded is a powerful determinant of equity of access to health care.

The funding of health care in Australia has become less equitable and less efficient, despite an increase in government expenditure.

This is because public expenditure, particularly at the Commonwealth level, has been increasingly directed at supporting the health care of the most advantaged groups in the community. This has occurred at the same time as increases in expenditure coming directly from consumers and a decline in the contribution from private health insurance funds.

The funding of the Australian health system is complex and includes a range of funders including Commonwealth, State and Territory governments, consumers, private health insurance funds and private non-profit and for-profit organisations.

Reform to health funding must look carefully at the roles and responsibilities of all funders of the health system as well as those who deliver and regulate health services. A priority must be placed on the accountability of private health insurance funds and private hospitals in meeting the goals of and equitable and efficient health care system.

The Australian Government is the only entity with the power to effectively lead the reform of the Australian health care system. However, it must be recognised that the provision of health services is, and should continue to be, a shared responsibility between the Commonwealth and the States. The Commonwealth must therefore work collaboratively with the States in reforming the health care system.

ACOSS is broadly supportive of a model in which the Commonwealth is responsible for funding the health care system through tax revenue and ensuring that all Australians have access to quality services to at least minimum national standards while the States/Territories are responsible for identifying the health care needs of local communities and designing and delivering appropriate services. The Commonwealth would be responsible for holding State/Territory Governments accountable for performance against agreed and consistent national criteria on equity, effectiveness and efficiency.

However, it is increasingly recognised that the sustainability and legitimacy of any major policy depends on how well it reflects the underlying values of the public. As governments deal with difficult choices on health care, policy needs to be informed by ordinary "unorganised" citizens, as well as organised interest groups. A full public inquiry is therefore required with genuine processes to elicit the informed opinions of citizens on the future shape of the health care system and the values which should underpin it.

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Health Care Financing

ACOSS continues to advocate a health system that provides an appropriate balance between public health and treatment services; quality health services provided according to need; low or no payments by consumers at the time of service; revenue raised according to ability to pay through taxation or a health levy; and methods of resource allocation and cost control that ensure efficient production of health services.

ACOSS has supported a number of government initiatives: the provision under Medicare of Extended Primary Care items to encourage GPs to work with other health professionals on case management; the inclusion in MedicarePlus of Medicare payments to allied health services for people with chronic conditions, and plans to train more GPs and allied health professionals; the election policy to pay for 2 yearly health checks for Indigenous people.

Both the Prime Minister and Minister for Health have stated the government's commitment to Medicare principles and the Coalition's election document (100% Medicare) stated that 'the Howard Government is committed to protecting and strengthening Medicare and delivering high quality, affordable health care to all Australians'. The Australian Government, through the Australian Health Care Agreements with the State and Territory governments, has established the principle that 'access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period'. ACOSS considers that a number of the Government's key policies are producing outcomes that are in conflict with the Government's objectives of affordable health care for all Australians by contributing to higher cost in the health care system and health care according to need.

The Private Health Insurance Subsidy is having serious consequences for lower income patients who are dependent on the public hospital system in accessing important medical and surgical treatments. Given the shortage of medical and nursing specialists the significant increase in private hospital use by insured people has come about as a result of transferring resources from the public hospitals and patients to private hospitals and patients. Costs of services in private hospitals are higher than in public hospitals thus contributing to higher inflation in total health expenditure.

The MedicarePlus Safety Net is contributing to price inflation of doctors' fees and distributing benefits inequitably. In the short time it has operated Safety Net payments are already much higher than the Government predicted, and, some doctors have restructured so that they are eligible for the subsidy. Based on past experience, it is likely that there will be further increases in doctors' fees over and above the Medicare Schedule of fees and benefits, making access to services even more difficult for low income people. Safety Net payments have gone disproportionately to high income groups who already have better health and better access to health services than do low income groups.

In summary ACOSS is concerned that:

- the Private Health Insurance Subsidy results in services being allocated to patients on the basis of ability to pay and not according to the principle of need
- the Private Health Insurance Subsidy does not have any mechanism to ensure that the private health service providers provide services in an efficient manner
- the MedicarePlus Safety Net is increasing the capacity of doctors to charge above the schedule fee and that this reduces their willingness to provide services in the public sector and adds to escalating health care costs.

ACOSS recognises that the Australian Government is committed to maintaining the role of private health insurance in the health care system. Within this framework the following recommendations seek to improve equity of access to health care for all Australians, especially low income Australians, and to improve efficiency of service delivery.

Recommendation 1

The Australian Government, in consultation with State and Territory governments and the community, should develop:

(i) A Charter of Medicare Entitlements which sets out:

- *the principles which underpin a universal health insurance system in which the private sector has a major role*
- *Medicare Entitlements to Services – the services that the Commonwealth will fund for Australians whether public or privately insured and the maximum time that individuals should have to wait for service for major services (regardless of whether privately insured)*
- *the additional benefits, entitlements or privileges that are available to privately insured persons*

(ii) A Charter of Mutual Obligations which requires:

- *the public and private sector to work together to ensure that services are allocated according to need and within the times specified in the Medicare Entitlements to Services, regardless of insurance status*
- *public and private health service providers who receive Commonwealth funding to meet efficiency and other standards set by the Commonwealth*
- *public and private sector health service providers to keep fees and charges to agreed levels (the Australian Health Care Agreements already defines this for public sector providers)*
- *mechanisms by which the Commonwealth, States and Territories, and private sector providers will ensure that the elements of the Charter of Medicare Entitlements and Charter of Mutual Obligations will be implemented and enforced.*

Recommendation 2

The exemption from the 1% Medicare Levy surcharge for tax-payers who take out private health insurance should be removed. The income threshold above which the surcharge applies should be changed from $50,000 for single people and $100,000 for couples and families to a flat $75,000. The extra revenue generated from this measure should be used to fund greater investment in Indigenous health, oral health and community based health care services in areas of low service supply.

Recommendation 3

The 30 per cent Health Insurance Rebate should be abolished from July 2005 in respect of ancillary health insurance. The extra revenue generated from this measure should be used to fund greater investment in Indigenous health, oral health and community based health care services in areas of low service supply.

Review of Election and MedicarePlus Policies

The operations of the MedicarePlus Safety Net have already shown to be inappropriate: payments are much higher than predicted by the government; large subsidies go to people in high income electorates and low subsidies to people in low income electorates, despite the fact that people in high income areas already have higher standards of health and better access to health services; groups of doctors have already restructured their fees so that a larger proportion of fees are covered by the Medicare; the Safety Net is likely to result in further inflation of doctors' fees in high income areas where doctors have traditionally charged above the scheduled fees.

The increase in the Private Health Insurance Subsidy for Older Australians announced in the election campaign further reduces the principle of access to health care according to need and strengthens the principle of access to care according to ability to pay. The proposal will further reduce the viability of private health insurance by encouraging people with high health care needs to join the funds while providing contributions less than the costs. Continuing instability of the private health insurance sector diverts attention from the need to find more equitable and cost efficient ways of providing health care for all Australians.

Recommendation 4

The Government should undertake a review of the MedicarePlus Safety Net and the increased Private Health Insurance Subsidy for Older Australians with a view to using the funds for the high need groups in ways that do not contribute to inflation of health care costs and increase problems of equitable access to health care services.

Reviewing and monitoring the impact of user fees

User fees are an increasingly central part of the health system, yet the effects of health care co-payments have not been subject to rigorous research or monitoring.

Recommendation 5

The National Health and Medical Research Council should commission research into the impact of health care co-payments (PBS, MBS, pathology and diagnostics) and other costs in accessing health care. The research should include a focus on the health care costs of people with a chronic illness and any trade-offs they report between health costs and other basic cost of living expenditure.

Better access to primary and community health care

Recommendation 6

The Government should commission research and development studies on the full range of options for the future planning, development, funding and delivery of health services, with the aim of rebalancing the system towards primary and community health care. This should begin with a synthesis of the evidence from the many partial and GP-focussed initiatives to date, and should form the basis for strategies to build GPs into a wider system, rather than providing wasteful incentives for them to compete with existing state-funded community health services. The study should include consideration of the effective use of allied health professionals and the training and funding implications that flow from this.

Community-based health care

Community-based health services are a critical part of Australia's health care system, providing vital preventative and allied health services in the community and the home. They also provide an alternative setting through which medical services can be delivered, for example, through the employment of salaried doctors or nurses in community health centres. Investment in community-based health care thus offers one avenue for offsetting the patchiness of bulk-billed GP services and would be a cheaper, more multi-disciplinary and more effective alternative to the current piecemeal approach of uncoordinated incentives to individual GPs.

Recommendation 7

The Australian Government should demonstrate its policy leadership in supporting community-based health services by investing substantial funds to drive enhancements in the availability, scope and standard of community based health care services. This should initially be targeted to areas of greatest need and aimed at overcoming the inequities in the distribution of health care resources created by the combination of Medicare payments

following the distribution of doctors, access to Pharmaceutical Benefits Scheme drugs following the distribution of dispensaries and the operation of private health insurance arrangements which favours wealthier areas over poorer areas.

Indigenous health

Despite vast differences in health status, there is little difference in per capita health care expenditure Indigenous and non-Indigenous populations. To make significant changes in the health status of Indigenous people, there needs to be a level of resources commensurate with need, and a process that guarantees that those resources are actually used in a way which improves the health of Indigenous communities.

Recommendation 8

The Australian Government should continue to boost resources to Aboriginal and Torres Strait Islander community-controlled health services, and determine the allocation of these resources through a process of consultation with the other signatories to the Aboriginal and Torres Strait Islander Health Framework Agreements, consistent with Aboriginal Health Regional Plans.

Oral health

The deep inequality in access to dental care for adult Australians is well documented. Affluent Australians — about a third of the population — can receive high quality private treatment promptly, supported by a heavy tax payer subsidy. Low income Australians (about another third of the population) on the other hand, experience lengthy delays or miss out on treatment altogether, under an inadequately funded public system. Arguments that dental care is a 'non-health' issue or state responsibility ring hollow once the extent of the massive subsidy of dental costs through the private health insurance rebate is considered. One analysis puts the amount at between $316 and $345 million per annum[1] and shows that the wealthy are by far the greatest beneficiaries, after taking into account all sources of government funding and subsidies for dental care.

Recommendation 9

The Australian Government should provide immediate targeted funding for those groups that are most disadvantaged by the current system and where dental health needs are clearly demonstrated by worse dental health outcomes than those in the broader community. Particular groups include: nursing home residents, Indigenous people, Australians living in rural and remote areas, people with a disability, people who are homeless, people with a mental illness and people on social security benefits.

Mental health services

The Commonwealth has a long-standing commitment to mental health reform, backed up by a strong research and development program and incentives to the states and territories for reform. State comparisons from the national report cards produced to date, reveal uneven progress in support for community sector mental health service delivery and areas of lingering crises. Mental health services cannot be expected to work in isolation from other sectors of the health system and the wider community sector. The focus of the Commonwealth's promised review of mental health policy should be aimed at focussing the Third Mental Health Plan on community and primary health care sector support for mental health service delivery. Models for supporting mental health in these settings already exist and do not need further research. Rather, there needs to be a development and

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[1] Spencer AJ (2001) *What options do we have for organising, providing and funding better public dental care?* Australian Health Policy Institute: Sydney

dissemination agenda supported by the Commonwealth.

Recommendation 10

The Commonwealth should provide resources for training and development to strengthen the capacity of primary health and community care services to deliver mental health care.

Savings under the Pharmaceutical Benefits Scheme

The Government extended eligibility for the Commonwealth Senior's Card in the 2001-02 budget, directing critical resources to many middle income retirees.

Recommendation 11

The Australian Government should reverse its decision to extend eligibility for the Commonwealth Senior's Card to middle income retirees.

Many drugs are listed on the Pharmaceutical Benefits Scheme for specified indications and for use after lower priced drugs have been found not to be satisfactory. It is well known that these restrictions are often not observed and that this type of prescribing can impose very high costs on the Scheme.

Recommendation 12

Research into drug utilisation, particularly into prescribing outside Pharmaceutical Benefits Scheme conditions, should be undertaken on a substantially larger and more coordinated scale. There should be greater monitoring of the prescribing patterns of practitioners and feedback to practitioners.