ACT GOVERNMENT SUBMISSION TO HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

JUNE 2005

A. Summary of ACT Government position

The ACT Government is prepared to support reform that will streamline the complex intergovernmental arrangements currently in place for the delivery, administration and financing of health services in Australia. The current system does not always provide the best health outcome for consumers and pressure continues to build on scarce health resources in an environment of rapidly increasing costs and an ageing population. All sensible suggestions for change to improve the efficiency and effectiveness of the provision of health services must be considered in a positive way.

The parties involved in the federal healthcare system at all levels acknowledge that they aim to provide the highest quality and most accessible health services that Australia can afford. But the reality is that the current division of governmental responsibilities for service provision and funding often means that users of the system are not receiving optimal treatment in the most clinically appropriate setting. This results in poor health outcomes for the patient and additional longer term financial costs for governments. The shortcomings of the current system also mean that not enough effort is directed towards prevention and health promotion and incentives for continuity of care are often lacking. These less than optimum conditions lead to poor health outcomes and the community incurs a range of avoidable costs.

Public hospitals continue to be the focus of the health system in Australia and the Australian Government must face up to its responsibility to adequately fund the increasing costs of the public hospital system. The existing indexation arrangement in the Australian Health Care Agreements (AHCAs) and the Public Health Outcomes Funding Arrangements (PHOFAs) do not properly reflect the escalating costs of the hospital system and the Australian Government must adopt a fairer and more realistic method of indexation. The AHCA indexation includes a demographic, as well as a utilisation factor, in addition to the Wage Cost Index Series 1 (WCI-1). The WCI-1 indexation has been approximately 2% per annum over the last three years while over the same period the Australian Government has approved an average increase of about 8% per annum in private health insurance premiums, mainly to cover the increased costs of health services.

The Australian Government's significant subsidisation of private health insurance does not appear to be proving effective in the ACT in terms of taking the pressure off public hospitals. The ACT continues to maintain the highest proportion of its population with private insurance cover (52%) in the country while its private insurance utilisation is one of the lowest with only 30% of total hospital separations in 2003-04 relating to patients using their health insurance. The ACT Government believes the people of the Territory would derive more benefit from an increase in funding to the public hospital system rather than the subsidisation of private health insurance.

The ACT strongly supports the decision governments took at the 3 June 2005 Council of Australian Governments meeting that Senior Officials would consider ways to improve Australia's health system across a range of areas and report back to it in December 2005 on a plan of action to progress these reforms. The ACT is prepared to cooperate fully with the Senior Officials review and hopes that it will achieve its

objective of clarifying governmental roles and responsibilities, and reducing duplication and gaps in services.

B. Health funding issues

The ACT has a high quality health system that provides good care for ACT residents and the surrounding region. The preliminary 2003-04 admitted patient care data shows were about 69,000 separations from ACT public hospitals and the three private hospitals accounted for about 32,000 separations. Community care and non-government services provide a range of care including aged care, drug and alcohol, dental and indigenous health services, and the ACT Health Action Plan 2002 indicates that about 85 per cent of people in the ACT see a general practitioner each year.

The ACT has argued for growth in the Australian Health Care Agreements (AHCA) and Population Health Outcomes Funding Agreements (PHOFA) funding well above the indexation applied under the current agreements, based on the range of pressures on health services costs as follows:

- The escalation in the cost of health services – health costs are increasing at a much greater rate than the general cost of goods and services
- Changing demographic factors – despite the relatively low population growth in the ACT (approx 0.8% per annum), the number of aged persons over 65 years (who are major consumers of health services) is expected to grow by 59% over the next decade compared to 37% nationally
- Impact of non-demographic factors – the changing nature of clinical practice has resulted in a much greater reliance on new and expensive technology and pharmaceuticals.

Cost escalation factors

The Commonwealth Grants Commission has reported that over the five years from 1996-97 to 2000-01 growth in total hospital expenditure has averaged 6.44% per annum, far in excess of other areas of the Australian economy. This has occurred at a time when wages and consumer price index increases have been minimal, running at 3.5% and 2.5% respectively. The latest Commonwealth Grants Commission report states that "the cost of providing inpatient services to State populations accounts for a high proportion of State net expenses – an average of 15 per cent over the years 1998-99 to 2002-03."

The latest ABS figures show that for the year to the end of June 2004 health costs rose by 6.6% (with hospital and medical costs rising by 8.6%) against a CPI increase of 2.5%[1] while the Wage Cost Index Series 1 (WCI-1) has averaged about 2% per annum across recent years.

The Australian Government's decision to index costs under the AHCA and PHOFA using the WCI-1, places an unfair burden on the states and territories which must fund a disproportionate share of the ongoing annual cost increases from their own resources in order to maintain service levels.

[1] Australian Bureau of Statistics, *Consumer price index, June Quarter 2004*, Canberra July 2004

It is a telling fact that the Australian Government has approved average increases in private health insurance premiums of 7.96% in 2005, 7.58% in 2004 and 7.4% in 2003. These increases are predominately due to the considerable health cost increases in recent years.

As a minimum, the ACT Government is asking that the Australian Government provide indexation equivalent to the Consumer Price Index plus 0.5%, acknowledging that this will still not adequately cover the real increases in hospital and related costs, but is based on the recommendations of the independent arbiter, Mr Ian Castles, engaged to determine an appropriate indexation factor during negotiations of the last round of AHCAs. The Australian Government rejected this recommendation opting for the WCI-1 because it was a less expensive option.

It is incongruous that at the same time as the Australian Government approves increases of an average 8% per annum in private health insurance premiums it will only provide the states and territories with indexation of 2% under the AHCAs. It is only fair and reasonable that the public hospital system is treated on the same basis as the private sector.

As part of the process for the renegotiation of the AHCAs, the States and Territories have argued that cost escalation factors relating to health goods and services and wages for health professionals are higher than the cost factors facing the general economy. For example, the ACT's average cost per casemix adjusted separation over the period 1999-00 to 2003-04 (excluding depreciation) increased by an average of 5.33% per year.

Failure to fund the increase in health costs will require the reduction of health services to the ACT community as the gap continues to grow between the cost of services and the funding available to provide those services. This will have significant negative health and political outcomes.

The increasing reliance on technology and pharmaceuticals and the volatility of the Australian dollar are major contributors to the cost pressures facing the health system. New drugs and implants are generally more expensive than previous innovations due to the application of advanced technology and the need to recoup development costs.

The hospital system is a major consumer of capital expenditure, for which they are fully funded by states and territories. Inadequate provision for depreciation of these assets puts at risk the health system's capacity to meet community health needs and expectations. While the capital consumption of about 8.3% of Australian public hospitals operating costs includes buildings and equipments, hospital services are increasingly being provided through the application of major capital items.

Failure to recognize the depreciation of these assets restricts the capacity of the system to provide the full range of diagnostic and treatment services required to meet the Government's commitment to a comprehensive and high quality public hospital system. The growing complexity of treatment options based on expensive equipment will increase the depreciation cost for health services in the future.

Diseconomies of scale

The ACT Government has made a commitment to provide a comprehensive health service for the ACT community. As a result, 95% of hospital services required by ACT residents at public hospitals are provided within the ACT.

This commitment creates diseconomies of scale. Procedures recording less than 20 separations per annum account for 44% of all public hospital activity. Services with less than 50 separations per annum account for two-thirds of all activity. However, a full operational service is required to provide the (almost) full range of hospital services for ACT residents.

The small ACT population base also affects the capacity of private hospital providers to provide a comprehensive range of services. Based on estimates of hospital separations per 1,000 population, ACT private hospitals offer about 20% less admitted patient services than their counterparts interstate, principally due to the size of the ACT population.

The diseconomies of scale that the ACT experiences, due to its small population, places increased pressure on the public sector which is required to provide some of the services not offered in private hospitals.

Demographic change and hospital throughput

Over the ten years to 2014, the ACT population is expected to grow by a total of 7.08%. However, the number of hospital separations is expected to increase by around 31% over that timeframe.

Based on the ACT Chief Minister's Department population projections, in 2004 there were 30,450 persons aged 65 and over, comprising 9.3% of the total ACT population. In 2003-04, persons aged 65 and over account for 32% of public hospital separations. This group is forecast to grow at 5.9% per year to reach 48,450 in 2014, to be 13.6% of the ACT population. This is more than seven times the overall population increase of 0.8% per year for the ACT. By 2014, the hospital separations for this age group is expected to increase by almost 75%.

Total public hospital separations in the ACT have risen by 11% over the past three years (from 2001-02 to 2003-04). However, medical services (i.e. not surgical activity) have increased by 18%, cancer services has increased by 7% and surgical activity has increased by 6%. Clearly, this adds significantly to pressures on health care costs.

Over the last decade, emergency admissions have become a significant part of the workload for public hospitals. Presentations at Canberra's two emergency departments have increased by 23% over the six-year period from July 1998 to December 2004.

Non-demographic change

The Intergenerational Report released with the 2002-03 Australian Government Budget reviewed historical trends and projected future growth in Commonwealth-funded health expenditure. Non-demographic growth factors have accounted for around 2.1% to 3.2% of growth on health spending over the last decade.

Workforce shortages and changes affect the ability of the health system to provide comprehensive and contemporary health care. There are already shortages of professional staff in a range of clinical areas within the hospitals and in community care. The capacity to attract and maintain a comprehensive health care workforce is dependent on the capacity of the ACT to at least meet wage outcomes in NSW and Victoria.

Pressures on health expenditure over and above the effect of prices, wages and population changes are growing in industrialised countries, due to advances in medical technology and practice (such as stents, provision of multidisciplinary aged care, provision of non invasive ambulatory care and new drugs).

More people are surviving events that previously would have lead to death, for example, people with heart failure, renal failure and cancer, whose ongoing costs are significant. This effect is often termed "expansion of morbidity" which means people are living for a longer time with disabilities.

The capacity to diagnose and treat diseases and conditions through the use of new technology, including expensive capital equipment and high cost drugs, places large pressures on the health system. While some of these interventions reduce the need for more invasive and costly services, the existence of the technology increases demand for new services that were previously unavailable or only available selectively.

In many cases, the provision of less invasive care delays, rather than eliminates, more costly surgical or medical procedures. Consumers expect the highest level of care and access to the latest pharmaceuticals and diagnostic and treatment services.

C. Response to the Terms of Reference

a. Roles and responsibilities of the different levels of government (including local government) for health and related services

The ACT strongly supports the decision governments took at the 3 June 2005 Council of Australian Governments meeting that Senior Officials would consider ways to improve Australia's health system across a range of areas and report back to it in December 2005 on a plan of action to progress these reforms. The ACT is prepared to cooperate fully with the Senior Officials review and hopes that it will achieve its objective of clarifying governmental roles and responsibilities, and reducing duplication and gaps in services.

The Committee should be aware that under the ACT's model for self-government, implemented in 1989, there is no local or municipal government. The ACT

Government has responsibility for local government matters in addition to its responsibility for provincial matters such as school education, policing, public hospitals and roads and traffic. The Territory is a geographically compact area and the government can effectively provide all services including municipal services. It has only two public hospitals and a small central administration for health services.

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

The ACT Government made clear its dissatisfaction with the inadequate funding offer made by the Australian Government in relation to the current AHCAs and PHOFAs. The ACT Government also made clear in its submission to the Senate Select Inquiry into Medicare – General Practice Access and Affordability, the inadequacy of the strategies proposed in the Australian Government's "Fairer Medicare" package, to improve GP access and affordability. The recent changes to Medicare safety net will also have an impact on GP access and affordability. The ACT Government is concerned that states and territories are increasingly being left to shoulder a growing share of health system funding.

Integration of Services

More work is needed to improve coordination and integration of services, and improve interface between primary, acute, aged and community care. This involves improving continuity of care across health and community care system, introduction of flexible funding models and social models of care involving closer interaction between health and other social policy portfolios.

Under the AHCA, the ACT, along with other States and Territories, has committed to national reform in a number of areas including improving the interface between hospitals, primary and aged care services, and achieving continuity between primary, community, acute, sub-acute, transition and aged care.

The ACT Government has been actively pursuing solutions to hospital interface issues not only through the AHCA reform agenda activities, but also through ongoing representations and negotiations with the Australian Government. As part of these negotiations the Australian Government provided funding to improve after hours GP services and agreed for ACT to use the Pathways Home funding, under the AHCA, to assist in the development of a sub-acute facility to provide improved services for older persons following hospitalisation.

The ACT Government supports the initiatives to improve integration of health services and is keen to seek mechanisms to make them more commonplace in the health system and less time consuming to negotiate with the Australian Government.

Australian Health Care Agreement (AHCA)

It is recognised that the Australian Government has increased funding for public hospitals, but its contribution is capped and limited to specific growth and indexation factors under the AHCA. In addition, the Australian Government does not contribute

to the capital costs of public hospitals. States and Territories are concerned that they bear the pressure in responding to demand growth. Adequate indexation also remains an issue for the ACT, noting that non-acceptance of the independent arbiter's recommendations resulted in a loss of $867 million nationally over 5 years of the AHCA. The ACT would have received an extra $14 million over the 5 years if the independent arbiter's indexation was applied.

Public Health Outcomes Funding Agreement (PHOFA) and Australian Immunisation Agreement (AIA)

The ACT continues to have concerns regarding the PHOFA methodology and funding. The first year (2004-2005) funding used the WCI-1 (estimated at 2%) applied to the base 2003-2004 PHOFA funding for each jurisdiction. The total PHOFA pool for all jurisdictions for subsequent out years is to be indexed, again by WCI-1 (estimated at 1.86% each year).

From Year 2 (2005-2006) the $3 million 'flagfall' for the three smaller jurisdictions is to be deducted from the total pool. The remaining pool is then distributed to jurisdictions based on a formula that applies a mix of population health related indices including population, disability, disadvantage, mortality and indigenous health.

In the out years, this distribution may vary substantially depending on population ratio and the indices applied.

The PHOFA includes what the Commonwealth described as 'new incentive payments'. A base payment of 96% of the allocated funds will be paid at the beginning of a financial year. The remaining 4% will only be paid on timely reporting. This has cash flow implications and cannot really be considered as an incentive payment for timely reporting.

Some of the performance indicators for the PHOFA are dependent on information to be supplied by external organisations (e.g. Australian Institute of Health and Welfare (AIHW), National Centre in HIV Epidemiology and Clinical Research). It is unreasonable to make jurisdictions liable for the provision of information and data, the timely provision of which is beyond their control.

The ACT welcomes, however, the removal of the immunisation components of previous PHOFAs into a separate AIA. The financial administration of the AIA remains highly complex, including 'clawbacks' and accounting for rollovers.

The ACT suggests that consideration be given to incorporating the PHOFA as a separate schedule of the AHCA. This has the potential to simplify and make more efficient all performance reporting and financial acquittal procedures.

Home and Community Care (HACC)

The HACC program provides a range of support services that enable people to continue living in the community. This improves health and lifestyle outcomes and reduces demand on more complex and acute care services.

The Australian Government and the ACT fund HACC jointly. The increase in the level of funding allocated to the program over the last decade provides evidence of the acceptance of policy makers, at all levels of government, of the growth in need of these services as the population ages and the life span of people with chronic and complex care needs continues to increase.

The National Program Guidelines provide a clear summary of roles and responsibilities of the respective governments. The HACC programs governance includes the Amending Agreement. The roles and responsibilities of both State/Territory and the Australian Government will be closely examined in the context of the negotiation of a new HACC Amending Agreement currently in progress.

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

The current comprehensive reporting of all aspects of hospital operations that the ACT must undertake in accordance with the AHCAs, National Hospital Cost Data Collection and the ACT Government's reporting to the ACT Legislative already ensure a reasonably high standard of accountability for the quality and delivery of hospital services. Reporting more data about hospital activity will not necessarily improve accountability but the efforts of health information managers should be directed at improving and standardising the current approaches.

Nationally agreed definitions exist but differences in the way the data is collected across jurisdictions makes meaningful comparison difficult. The methodologies underlying the reporting of hospital activity differ in the various forums they are reported eg the AHCA and AIHW. The reporting approaches are based on complex concepts that the layperson often finds difficult to understand. It would be desirable to move to a standard reporting approach as this would reduce the confusion and misunderstandings that frequently occur when people try to understand and interpret the data as it is currently reported.

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

The ACT population places great trust in its public health services. The ACT reports 109 private hospital separations per 1,000 population against a national average of 130 per 1,000 population. This compares to public hospital demand of 235 separations per 1,000 population against the national average of 206 per 1,000 population. This level of demand for public services in the ACT places increased demand on ACT public hospitals.

Both sectors involved in the provision of health care should be committed to strengthening the continuum of care concept in the treatment of patients. The private

sector has an important role to play in concert with the public sector and that role needs to be properly defined and where necessary the legislative changes made to allow the private sector to become more actively involved in primary care and aged care provision. The two sectors need to work together cooperatively and it is essential that private hospitals are more actively involve in state health department planning processes.

In order to make private health funds more attractive they need to be able to offer more gap insurance products that reduce the out of pocket expenses, often substantial, that private hospital patients are required to meet after their hospital stay.

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

The data continues to show that ACT residents do not perceive private health insurance as a value for money proposition. The ACT has the highest rate of private health insurance coverage in Australia but one of the lowest private insurance utilisation rates.

The latest survey of health membership conducted by the Private Health Insurance Administration Council (PHIAC) reveals that for the year ending December 2004 with 52% of its population, or 168,000 people, holding private health insurance the ACT continues to maintain the highest rate of private insurance coverage of all the states and territories. The rate of coverage for all Australians in the same period was 43%.

ACT results of PHIAC health insurance survey as at 31 December

	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
% ACT population with health insurance	33.8	35.3	55.5	55.4	52.0	51.9	52.0
% annual difference		4.8	60.8	0.9	-5.5	0.1	0.6

In every year since 2000, PHIAC's ongoing annual survey has shown that more ACT residents hold private health insurance than any other jurisdictions. Since 2000 an average of 53.4% of the population hold private health insurance compared to the Australian average of 44.1%.

The numbers of people taking out private insurance cover increased significantly after the Australian Government introduced Lifetime Health Cover on 1 July 2000. The unparalleled increase in the proportion of the ACT population with cover from 35.3% in 1999 to 55.5% in 2000 was in line with the national trend that saw coverage increase from 31.2% to 45.4%. Clearly, this has been the only effective measure to increase private insurance coverage.

However, despite the high proportion of ACT residents with private health insurance

cover when we look at their utilisation of private hospital services they are overwhelmingly opting for treatment in the public hospital system. The private patient separations from hospitals as reported in the total hospital throughput reported in the preliminary 2003-04 ACT admitted patient care database shows that 30% of all separations relate to patients using private health insurance.

Separations from all ACT hospitals 2001/02 to 2003/04

	2001/02		2002/03		2003/04 (note 1)	
patient status	separations	% total activity	separations	patient status	separations	% total activity
Privately insured (note 2)	24,302	26.2%	27,269	27.8%	31,763	30.0%
Public	55,709	60.0%	57,962	59.2%	65,602	62.1%

Note 1: preliminary 2003-4 ACT admitted patient care database
Note 2: includes private patients in the public system as well patients in the Territory's three private hospitals

Patients are not required to use their private health insurance when they attend a public hospital for treatment. The ACT also has one of the lowest incidences nationally of patients using their private hospital insurance in the public hospital system. Preliminary 2003-04 data indicates that only 4.4% of people treated in public hospitals used their private health insurance. The comparable figure in 2002-03 was 4.8%, with only the Northern Territory recording a lower outcome in that year. The 2003/04 national average was 7.2%.

The preference of residents of the ACT and surrounding regions to choose public hospitals for their treatment is testament to their confidence in the public system. From the Territory's perspective it would be more effective for the Australian Government to spend the funding allocated to subsidisation of private health insurance directly on public hospitals.

Access to private hospital services is contingent on the availability of private hospitals facilities and private specialists to provide the services. The ACT has low numbers of private specialists and ACT private hospitals provide a more limited range of services than private hospitals elsewhere in the country, with the exception of the Northern Territory. The ACT is situated in a geographically compact area and is well served by its two public hospitals. Consequently its residents do not utilise private hospitals to the same extent as others in the country. The ACT Government maintains that since the Commonwealth began introducing measures to make private health insurance more attractive all the evidence indicates that ACT residents would gain more benefit from the allocation of funding directly into public sector services rather than the private health insurance rebate.

Public hospitals are subsidising patients who elect to use their private insurance on entering the public system because public hospitals cannot recover the same level of costs from the insurance funds for private patients as the private hospitals recover.

The Australian Government could use its regulatory power over private health insurance funds to allow public hospitals to charge at the same rate as the private sector and require the funds to meet these charges.

The scope of private health insurance could be extended to provide coverage in line with the continuum of care reform agenda.