Executive Summary

Introduction

Australia delivers some of the best quality and best value hospitals and primary healthcare in the world. Compared with other countries, Australia performs strongly across a range of important health indicators. For example, life expectancy for Australian women is the sixth highest globally, and for men it is the seventh highest.[1] At the same time Australia's spending on health as a percentage of GDP (9.1 per cent) is lower than comparable OECD countries such as the United States (17.0 per cent), France (11.2 per cent), Canada (10.6 per cent) and New Zealand (10.3 per cent), and equivalent to the United Kingdom and Spain (both 9.1 per cent).[2]

Since coming to power the Abbott Government has repeatedly called into question the sustainability of Medicare. The evidence given to this committee and documented in this report reveals the fallacy of such claims particularly with regard to GPs and the Medicare Benefits Scheme.

Despite the Prime Minister's promise to Australians on 6 September 2013, that there would be "no cuts to health",[3] the 2014-15 Budget abolished a number of national partnership agreements with the States and Territories. The cuts to health were met with the opposition from each premier and chief minister. The impacts on State and Territory budgets and the healthcare sector are already well documented and being felt in frontline delivery.[4] The 2014-15 Budget reveals cuts to health in the order of $50 billion dollars over the next ten years.[5]

In this context the Select Committee on Health was established on 25 June 2014. The committee has held more than a dozen public hearings across Australia. During its extensive consultations with stakeholders, the committee has heard of the widespread concerns for Australia's healthcare system resulting from the Abbott Government's 2014-15 Budget.

The other major concern expressed to the committee is the government's failure to consult with key stakeholders in announcing wholesale structural changes to a

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1 Australian Institute of Health and Welfare, *Australia's Health 2014*, May 2014, p. 69.

2 Australian Institute of Health and Welfare, *Health expenditure Australia 2011-12*, September 2013, p. 28.

3 The Hon Mr Tony Abbott MP, Opposition Leader, *SBS News*, 6 September 2013, www.sbs.com.au/news/article/2013/09/06/no-cuts-abc-or-sbs-abbott (accessed 18 November 2014).

4 www.abc.net.au/news/2014-05-14/budget-2014-states-react-to-health-and-education-cuts/5452234) (accessed 20 November 2014).

5 Australian Government, *Budget 2014-15, Overview*, p. 7, www.budget.gov.au/2014-15/content/overview/download/Budget_Overview.pdf (accessed 19 November 2014).

complex and highly integrated national system. For example the Australian Medical Association (AMA) has criticised the $7 co-payment on all bulk-billed GP consultations, out-of-hospital pathology and diagnostic imaging services as both ideologically driven and not based on credible evidence:

> The AMA is concerned that the Government's Budget measures therefore appear to ignore systemic opportunities to address health care spending. They appear to be driven by ideology rather than based on evidence and have not been developed within a vision and framework of systemic reform.[6]

Despite speculation since 2013 and the release of the Commission of Audit Report, the government did not consult key stakeholders. The list of those not consulted based on the evidence received by the committee includes:

- Australian Medical Association Tasmania
- Royal Australian College of General Practitioners
- Royal Australasian College of Physicians
- The Hon. Jay Weatherill, Premier, South Australian Government
- The Grattan Institute
- Australasian College of Emergency Medicine
- Australian Diagnostic Imaging Association
- Residential aged care
- Ambulance Employees Australia of Victoria
- Australian Nursing and Midwifery Federation (SA Branch)
- Aboriginal Health Council of South Australia
- Health Consumers Alliance of South Australia[7]

With regard to the closure of 61 Medicare Locals the government's failure to meet any of its own deadlines about the establishment of Primary Health Networks (PHNs) reveals the flawed nature of the process it has set in train. The government's lack of communication and consultation with vital participants in the health sector is of ongoing concern.

Although this inquiry runs until mid-2016, the committee has decided to report on its findings to-date given the scale and long-lasting negative impacts of the government's proposed healthcare "reforms". This interim report explores in detail the impacts of the government's proposed $7 co-payment, cuts to hospital funding for the states, the abolition of the Australian National Preventative Health Agency, and the closure of Medicare Locals revealed in the submissions and public hearings between August and

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6 Australian Medical Association (AMA), *Submission 48*, p. 5.

7 See Chapter 3 for references.

November. It also records the committee's findings regarding the amalgamation of the Organ and Tissue Authority and the National Blood Authority. Further enquiry into indigenous health will follow along with updates on the committee's findings in future reports.

$7 co-payment

During the committee's inquiry one issue raised repeated concerns: the $7 co-payment. The overwhelming sentiment of witnesses was that the $7 co-payment will have a negative impact on the health and wellbeing of all Australians and is practically unworkable.

In terms of negative impacts, the $7 co-payment was roundly criticised by witnesses and submitters for:

- Undermining the universal access principle on which Medicare is based.
- Disproportionately disadvantaging the health and life opportunities of the most vulnerable sections of the Australian community, especially indigenous Australians.
- Cost shifting to the states via increased emergency department visits and public hospital admissions (resulting in 500 000 and 290 000 additional visits per annum in NSW and South Australia, respectively)[8] as well as cost shifting to the Australian community through the accumulating payment of the $7 co-payments (estimated at $8.4 billion over 4 years).[9]
- Raising system-wide healthcare costs as a result of increased reliance on highly expensive hospital treatment over cost-effective primary care: 'If a person doesn't go to a GP and their condition deteriorates, they may end up in a hospital emergency department (which costs at least three times as much as a GP visit), being admitted to hospital (50 times the cost) or both.'[10]
- Research in the United States demonstrates that a co-payment acts as a barrier to healthcare access and leads to an increase in healthcare costs as those with preventable illness delay treatment and are admitted to hospital: 'The study of US medicare with people over 65…found that for every dollar saved through the payment of a $7 co-payment itself or through reduced demand could be directly traced to an increase of $3.35 in patient costs.'[11]

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8 Daily Telegraph, *NSW emergency fears due to GP co-payment*, 8 October 2014 and Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 5.

9 Australian Medical Association (AMA), *Submission 48*, p. 5.

10 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *The Drum*, 14 August 2014.

11 Mr Martyn Goddard, private capacity, *Committee Hansard*, 3 November 2014, p. 23.

- Introducing a price signal that is 'inappropriate for primary care because health care is not a commodity or luxury service; it is an essential service that can create much greater downstream costs if not used at the right time.'[12]
- Damaging health prevention and management by delaying or preventing people from seeking primary healthcare and thus failing to treat preventable illnesses or make early interventions: 'Given that laypeople, by necessity, are not experts in health, putting a financial barrier to them accessing people who are is very counterproductive...'[13]
- Imposing an additional cost burden on patients managing chronic disease, leading to worse health outcomes: 'Mental health is a good example where people regularly need to see their doctors and their counsellors. Sometimes they have a GP, a psychiatrist, a psychologist, counsellors, the works. When they are not adhering to their medical schedule, that is when they fall into a bit of a pit and paramedics get called out when they are at the point of real despair.'[14]
- Increasing red tape for general practice including complexities in administration—how the $7 co-payment will operate in practice; what services will attract the $7 co-payment; how can it be collected; additional costs for administration and collection of the $7 co-payment on GPs and other health providers: '…there is not a hope in Hades of developing by July next year the software that can cope with it [the $7 co-payment]—for us to have real-time information and to know, 'They have just been for an X-ray. Was that their 10th visit or not?' There is an impact upon general practice and pathology and radiology practices in terms of managing the collection of that small amount. What do we do? Put an extra secretary on? Except we are not able to afford it because we are giving up $16 out of $45 per consultation.'[15]

The committee is deeply concerned by the substantial body of evidence it has received regarding the negative effects of the government's proposed co-payments and the proposal to introduce a co-payment in emergency departments. More than 100 submitters and countless witnesses have expressed consistent and overwhelming opposition to the proposed $7 co-payments.

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12 Professor Jane Hall, Director, Centre for Health Economics Research and Evaluation, University of Technology, Sydney and Richard De Abreu Lourenco, Research Fellow, University of Technology, Sydney, *GP co-payments: why price signals for health don't work*, 10 July 2014.

13 Mr Stephen Burgess, Innovation, Policy and Research Officer, Benetas, *Committee Hansard*, 7 October 2014, p. 8.

14 Mr Hill, Ambulance Employees Australia of Victoria, *Committee Hansard*, 7 October 2014, p. 18.

15 Dr Martin Carlson, Moruya General Practitioner, *Committee Hansard*, 16 September 2014, p. 10.

Collectively, these concerns demonstrate the sheer size and scale of the impact of the government's proposed $7 co-payment.

It is the view of the committee that the government should immediately abandon its plan to implement the $7 co-payment.

Cuts to hospital funding

The committee heard widespread concerns about the government's proposal to significantly reduce state hospital funding. The cuts equate to a $50 billion reduction in funding over the next ten years. The government's proposal is to reduce indexation arrangements for hospitals and remove funding guarantees for public hospitals.[16]

The hospital funding cuts were also seen as detrimental to the hospital workforce and damaging to health outcomes of patients with acute conditions.[17]

Concerns were also raised regarding the government's move away from activity-based hospital funding back to the former block funding model. Witnesses argued that activity-based funding will drive cost-efficiencies within hospitals and also improve hospital expenditure transparency. Perversely, the committee was told that a return to block funding will provide an incentive for states to cost-shift back to the Commonwealth.[18]

Abolishing the Australian National Preventative Health Agency

The 2014-15 Budget also outlined the government's intention to abolish the Australian National Preventative Health Agency (ANPHA). The government has already incorporated ANPHA's functions into the Department of Health.[19] A number of witnesses identified the loss of ANPHA as a major issue.[20]

The committee heard that investment in health promotion is both highly cost effective and relatively cheap. It has been estimated that for every dollar spent on health promotion and prevention five dollars in healthcare expenditure alone is saved.[21]

Witnesses observed that despite the cost effectiveness of health prevention, Australia invests just two per cent of all health expenditure in health promotion and disease

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16 Australian Government, *Budget 2014-15, Overview*, p. 7, www.budget.gov.au/2014-15/content/overview/download/Budget_Overview.pdf.

17 Australasian College of Emergency Medicine, *Committee Hansard*, 8 October 2014.

18 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, pp 32–33.

19 Mr Andrew Stuart (Deputy Secretary) and Mr Nathan Smyth (First Assistant Secretary, Population Health Division), Department of Health, Senate Community Affairs Legislation Committee, *Committee Hansard*, 2 July 2014, Canberra, p. 48.

20 See for example evidence from Ms Meredith Carter, Spokesperson, VMAG, *Committee Hansard*, 7 October 2014, p. 2 and Professor Elizabeth Dabars, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, 9 October 2014, p. 29.

21 Dr Bruce Bolam, Executive Manager, Programs Group, Victorian Health Promotion Foundation (VicHealth), *Committee Hansard*, 7 October 2014, p. 22.

prevention programs—low by international standards. The government's plans to abolish ANPHA, coupled with its decision to cease the National Partnership Agreement for Preventative Health, will exacerbate this situation.

It is the view of the committee that the government should immediately cease its plans to abolish the Australian National Preventative Health Agency.

Medicare Locals

Medicare Locals are primary health care organisations that were established by the former Labor Government to coordinate primary health care delivery and to tackle local health care needs and service gaps.

The former government successfully established 61 Medicare Locals across Australia between mid-2011 and mid-2012.

Medicare Locals have delivered a wide range of primary healthcare services to the Australian community. For instance, a Medicare Local, in consultation with local GPs, can identify that there are a large number of patients with diabetes in a particular area and organise a roster of allied health professionals such as nutritionists and diabetes educators to provide sessional services to different GP clinics in that area. The services that Medicare Locals provide or coordinate are extensive and range from mental health services such as Partners in Recovery to podiatry or speech pathology and health promotion and prevention. The local nature of different community needs and service availability dictated the variation in the services and coordination each Medicare Local provided.

During the 2013 election campaign the then Opposition Leader, the Hon Tony Abbott MP made a promise that "we are not shutting any Medicare Locals".[22] Instead the government undertook to review Medicare Locals with a view to ensuring they were providing more "frontline Services".[23] Despite the Review, conducted by former Chief Medical Officer, Professor John Horvath finding that Medicare Locals were in fact providing a substantial number of frontline services[24] the government, in breach of its election promise, effectively announced that by July 2015 all Medicare Locals will cease operation.

The government's decision to abolish Medicare Locals and the process by which it has gone about informing Medicare Locals of this decision was heavily criticised by witnesses and submitters including:

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22 The Hon Tony Abbott MP (Opposition Leader), *People's Forum 2*, transcript, ABC News 24, 28 August 2013, www.abc.net.au/news/2013-08-28/medicare-locals/4919936.

23 *The Coalition's Policy to Support Australia's Health System*, Liberal and National Parties, August 2013, http://lpaweb-static.s3.amazonaws.com/13-08-22%20The%20Coalition%E2%80%99s%20Policy%20to%20Support%20Australia%E2%80%99s%20Health%20System.pdf, p. 3.

24 *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, Professor John Horvath AO, 4 March 2014, p. 4.

- concerns over the permanent loss of important primary care services delivered by Medicare Locals;
- loss of healthcare professionals as they seek alternative employment due to uncertainties over the future of programs run and contracts managed by Medicare Locals;
- the cost of closing Medicare Locals; and
- confusion about the role and timeline for the tender for PHNs and the late provision of the PHN boundary information.

The committee is concerned that the government's decision to close 61 Medicare Locals and establish a new system of 30 PHNs is causing loss of services particularly in rural and remote areas and loss of allied health workforces.

If the government is to pursue its decision to close all Medicare Locals then PHNs should be established on the basis of:

- a clear statement of the population health needs to be addressed, including clear outcome measures;
- a statement of the population health data expected to be collected or used;
- a statement on the outcomes PHNs will be expected to achieve to improve access to primary care and improve primary care integration for the whole population, in particular for disadvantaged groups; and
- a commitment that the integrity of the data collected by Medicare Locals will be preserved.

Merging healthcare agencies—Organ and Tissue Authority and National Blood Authority

The committee has also examined a specific instance of the "efficiencies" proposed in the 2014-15 Budget: the merger of the Organ and Tissue Authority (OTA) and the National Blood Authority (NBA).

In March 2014 the National Commission of Audit recommended the merger of the OTA and the NBA. The government accepted this recommendation, seemingly without analysis, in the 2014-15 Budget.

The committee heard evidence from both the OTA and the NBA about the possible savings that could be achieved as a result of the proposed merger. The committee considers the potential savings to be negligible and the effort and disruption required to achieve them unwarranted. The committee believes that the detriment caused by uncertainty for staff members and confusion for stakeholders, including state and territory governments, outweighs any potential benefits.

Furthermore, the committee is concerned that a merger between OTA and NBA would result in a loss of the focus that a single agency can bring to promoting organ donation. The proposed merger could reverse the positive trends in the rate of organ donation in Australia which have been achieved by the OTA.

On the evidence the before the committee it is clear that a merger of the OTA and the NBA would result in minimal, if any, "savings". The result is far more likely to damage the positive work done so far by the OTA, with the consequence that organ donation rates in Australia suffer.

The committee could find no evidence that thorough consideration or consultation had been undertaken with organ and tissue donation sectors on the impact of the merger of the OTA & NBA.

Accordingly, the committee is of the view that the government should cease its planned merger of the OTA and the NBA.

Indigenous Health

Evidence before the committee confirms the view that the government's health policy changes, combined with the cuts to indigenous health programmes, will have a significant deleterious effect on indigenous health. The committee will undertake specific and detailed analysis of the effects of government policy on indigenous health in a future report, and in the meantime calls on the government to reinstate funding and programmes for indigenous health.