

The Senate

Select Committee on
Health

First interim report

December 2014

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Terms of Reference

That a select committee, to be known as the Select Committee on Health, be established to inquire into and report on health policy, administration and expenditure, with particular reference to:

- a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
- b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
- d. the interaction between elements of the health system, including between aged care and health care;
- e. improvements in the provision of health services, including Indigenous health and rural health;
- f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- g. health workforce planning; and
- h. any related matters.

Acronyms and abbreviations

ABF	Activity Based Funding
ACCHS	Aboriginal Community Controlled Health Services
ACOSS	Australian Council of Social Service
AFAO	Australian Federation of AIDS Organisations
AHCWA	Aboriginal Health Council of Western Australia
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMLA	Australian Medicare Local Alliance
ANMF	Australian Nurses and Midwifery Federation
ANPHA	Australian National Preventative Health Agency
CHF	Consumer Forum of Australia
COAG	Council of Australian Governments
CPI	Consumer Price Index
ED	Emergency Department
FAQ	Frequently Asked Questions
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GP	General Practice
GPs	General Practitioners
HWA	Health Workforce Australia
HWF	Health Workforce Fund
ICT	Information and Communication Technology
MBS	Medicare Benefits Scheme
MRFF	Medical Research Future Fund
NACCHO	National Aboriginal Community Controlled Health Organisation
NBA	National Blood Authority
NHRA	National Health Reform Agreement
NHHRC	National Health and Hospitals Reform Commission
NGO	Non-Government Organisation
NPA	National Partnership Agreements

NPAPH	National Partnership Agreement on Preventive Health
NRP	National Reform Programme
OECD	Organisation for Economic Co-operation and Development
OTA	Organ and Tissue Authority
PBS	Pharmaceutical Benefits Scheme
PHNs	Primary Health Networks
PHCO	Primary Health Care Organisation
PHO	Primary Health Organisations
RACGP	Royal Australian College of General Practitioners
VMAG	Victorian Medicare Action Group
YACSA	Youth Affairs Council of South Australia

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

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 Australia⁷

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

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

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.

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

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 services²⁴ 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:

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.

Recommendations

Recommendation 1

The committee recommends that the government should immediately abandon its plan to implement the \$7 co-payments.

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

Recommendation 2

The committee notes the evidence of the negative implications of the government's:

- **changed hospital funding indexation arrangements that will see public hospitals funded on the basis of population growth and CPI;**
- **cuts to the National Health Reform Agreements and associated National Partnership Agreements; and**
- **lack of commitment to Activity Based Funding.**

The evidence points to a significant loss of health services in Australia's public hospitals if these changes proceed.

On the basis of the evidence to the committee, the government should restate its commitment to Activity Based Funding and associated reforms.

Recommendation 3

The committee recommends that, based on the evidence before it, and the demonstrated benefits arising from the work of the Australian National Preventive Health Agency (ANPHA) and the National Partnership Agreement on Preventive Health, the government should drop its plans to abolish ANPHA and reinstate the National Partnership Agreement on Preventative Health.

Recommendation 4

The committee expresses its concern that the government's decision to abolish 61 Medicare Locals and establish 30 new Primary Health Networks is resulting in a loss of frontline services that will see significant cuts to services and programs at the local level. Evidence to the committee demonstrates that Medicare Locals have been improving health outcomes, promoting better integration of primary care services and reducing the need for individuals to seek hospital care.

If the goal of better integration of primary care is to be achieved, the committee recommends that the Primary Health Networks tender must include:

- **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 Primary Health Networks 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 requirement that the integrity of the data collected by Medicare Locals will be preserved.**

In considering the applications for funding for Primary Health Networks the government should have a mind to the success of Medicare Locals in:

- **reducing hospitalisations**
- **improving access to after-hours primary care services**
- **reducing rates of chronic disease**
- **reducing smoking rates**
- **increasing immunisation rates**
- **improving access to mental health services**
- **improving access to allied health services**

Recommendation 5

The committee expresses its concern that the government's decision to abolish 61 Medicare Locals and establish 30 new Primary Health Networks is resulting in loss of frontline services and will see significant cuts to services and programs at the local level that are aimed at improving population health, better integration of primary care services and keeping people out of hospital.

Recommendation 6

The committee notes the government's ongoing failure to consult with community groups, peak bodies including GPs and allied health, and state and territory governments in relation to Primary Health Networks transition arrangements.

The committee recommends that the government, as a matter of urgency, ensures certainty in regards to the maintenance of the suite of services supplied by Medicare Locals, particularly in areas of rural and remote Australia where access to medical facilities and services is less comprehensive than the level of access in metropolitan areas.

Recommendation 7

The committee recommends that the government must take immediate steps to reinstate funding to indigenous health organisations and ensure that the particular health challenges facing Aboriginal and Torres Strait Islander Australians are effectively analysed and responded to.

Recommendation 8

The committee recommends that the government should cease its planned merger of the Organ and Tissue Authority and the National Blood Authority.

The committee could find no evidence that a thorough consideration of the impacts of the merger within either agency or the broader public and health sector had been undertaken. Further, based on evidence gained in hearings, any efficiencies to be achieved are minimal and the risks to each agency continuing to improve upon their achievements to date are high.

Chapter 1

Introduction

1.1 On 25 June 2014, the Senate established the Senate Select Committee on Health.¹ The reporting date for the committee is 20 June 2016. The committee's resolution allows the committee to make interim reports such as this one.

Public hearings

1.2 The committee began its inquiry by setting an initial submission closing date of 19 September 2014 and planning a comprehensive program of public hearings. To date, the committee has conducted hearings in:

- Townsville, Queensland, 21 August 2014
- Canberra, Australian Capital Territory, 28 August; 4, 25 and 30 September; and 2 October 2014
- Lismore, New South Wales, 15 September 2014
- Moruya, New South Wales, 16 September 2014
- Geelong, Victoria, 6 October 2014
- Melbourne, Victoria, 7 and 8 October 2014
- Adelaide, South Australia, 9 October 2014
- Perth, Western Australia, 10 October 2014
- Hobart, Tasmania, 3 November 2014
- Launceston, Tasmania, 4 November 2014

1.3 The committee anticipates that hearings in early 2015 will focus initially on Australia's primary care system, and other issues relevant to the committee's Terms of Reference.

1.4 Through this initial program of public hearings, the committee has taken evidence from many health experts and practitioners. It has also enabled the committee to engage the wider Australian community, including those in rural and regional areas which may not normally be able to talk to a Senate Committee. Further, by travelling to various states and territories, the committee has provided an opportunity for state and territory governments to participate at this initial phase of the committee's inquiry.

1.5 Unfortunately, despite numerous invitations, to date only the South Australian state government has participated in the committee's public hearings and provided a

1 *Journals of the Senate*, 25 June 2014, pp 996–998.

submission. The Queensland and Australian Capital Territory Governments have provided submissions but have not yet appeared before the committee. The committee is hopeful that they will participate in future hearings in Canberra and Brisbane in 2015. While the Northern Territory Government advised that it would make a submission, nothing has been received to date. The Victorian Government declined to attend hearings held in Victoria, well in advance of the November 2014 caretaker period. Western Australian Government officials at first confirmed their attendance but, just prior to the hearing day advised that they had to cancel without any reason being provided. The Tasmanian Government provided no response to an invitation to attend the committee's hearing in Hobart. The New South Wales Government declined the invitation to appear at a planned hearing in Sydney in late November.

1.6 The committee hopes that in the coming months of its inquiry that there will be opportunity to constructively engage with the state and territory governments.

1.7 The committee also made a number of site visits, including to:

- a public hospital in Far North Queensland and another in regional Victoria;
- a private hospital in Northern New South Wales;
- a General Practice and allied health clinic on the Southern New South Wales coast; and
- a Medicare Local integrated health services centre in Launceston, Tasmania.

Submissions

1.8 The committee has received over 100 submissions since the beginning of its inquiry.² While the committee is still accepting general submissions, it is the committee's intention to seek submissions on specific topics as the need arises over the course of the inquiry.

Structure of this report

1.9 This interim report is the first of a series with which the committee proposes to report on its findings and conclusions to date. The committee's terms of reference are wide-ranging and it is the committee's intention to explore the various issues in depth over the course of its inquiry. This first report will outline the issues brought to light by the committee's work to date, and focus in depth on three in particular:

- the government's proposed patient co-payments, cuts to hospital funding and the abolition of Australian National Preventative Health Agency (ANPHA) (Chapter 3);
- the government's plan to close the 61 Medicare Locals and replace them with 30 Primary Health Networks (PHNs) (Chapter 4); and

2 The submissions received by the committee can be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions.

-
- the merger of the Organ and Tissue Authority (OTA) and the National Blood Authority (NBA) (Chapter 5).

1.10 Patient co-payments, that is the \$7 "contribution" that the government is asking all Australians to pay for visits to GPs, out-of-hospital pathology and diagnostic imaging, has been raised as a key issue at every one of the committee's hearings. Although the government has so far supplied very limited detail on how the patient co-payments will work, the policy has drawn strong and consistent criticism across the health policy sector. This report marks the evidence heard by the committee to date and makes initial comment on the patient co-payments policy, cuts to hospital funding and the abolition of ANPHA. The committee will continue to monitor these issues as the government announces further details.

1.11 Focussing on the closure of Medicare Locals and the establishment of PHNs is timely. As the committee's report is tabled, the Department of Health has just released tender documents for the PHNs. During its inquiry, the committee has heard a number of significant concerns regarding the closure of the Medicare Locals and the transparency of the transition to the PHNs. With its first interim report, the committee seeks to publish these concerns and to make recommendations which, it is hoped, can be used by the government to achieve a better outcome for the primary healthcare sector and ultimately the patients that they care for.

Notes on references

1.12 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to the committee Hansards are to the proof transcripts.³

Acknowledgements

1.13 The committee thanks the many organisations and individuals that made written submissions, and those who gave evidence at the public hearings to date.

1.14 In particular, the committee thanks the staff of the various hospitals and health services who have hosted the committee's site visits, and the staff of the various Medicare Locals who have participated in the committee's inquiry to date. The committee also wishes to thank the numerous individuals who brought their own personal experiences with the healthcare system to the committee's attention.

3 Committee Hansards can be accessed via the committee's website:
www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

Chapter 2

The inquiry

Establishment of the Select Committee on Health

2.1 The resolution of the Senate Select Committee on Health requires the committee to inquire into and report on health policy, administration and expenditure, with particular reference to:

- (a) the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
- (b) the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- (c) the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
- (d) the interaction between elements of the health system, including between aged care and health care;
- (e) improvements in the provision of health services, including Indigenous health and rural health;
- (f) the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- (g) health workforce planning; and
- (h) any related matters.

2.2 In its initial work the committee has focused on terms of reference a to c, although the evidence taken at hearings and received in submissions has included information relevant to the other terms of reference.

Issues identified to date

Much of the evidence the committee has received during its 15 public hearings and gathered through submissions has focused on concerns about the government's cuts to healthcare spending, primary health, and health promotion. This focus is unsurprising when the scale of the cuts is considered. The following table, published by the Royal Australian College of General Practitioners, shows the breadth and depth of the cuts, particularly on primary care. The following sections discuss the key areas of concern raised with the committee during its deliberations to date.

Table 1—2014-15 Budget cuts to healthcare¹

Health budget overview	2014–2015	2015–16	2016–17	2017–18	Total
GP co-payments	+\$14.2M	-\$1.13B	-\$1.15B	-\$1.20B	-\$3.47B
General practice training	-\$16.4M	-\$40.9M	-\$35.9M	-\$22.1M	-\$115.4M
Doubling of Teaching PIP	\$20.5M	\$59.5M	\$75.4M	\$82.9M	\$238.4M
Primary Health Networks	-	-	-	-	-
General Practice Rural Incentives Program	\$35.0M	-	-	-	\$35.0M
Rural teaching infrastructure	\$21.0M	\$21.0M	\$10.5M	-	\$52.5M
Indigenous programs	-\$163.0M	-\$145.6M	-\$118.1M	-\$67.1M	-\$493.7M
Indigenous sexual health	\$25.9M	-	-	-	\$25.9M
Mental health – headspace	\$4.5M	\$1.4M	\$1.9M	\$7.2M	\$14.9M
Mental Health Nurse Incentive Program	\$23.4M	-	-	-	\$23.4M
e-Health / PCEHR	\$140.6M	-	-	-	\$140.6M
Medical Research Future Fund	-	\$19.9M	\$77.0M	\$179.3M	\$276.2M
Bowel Cancer Screening Program	\$3.8M	\$7.6M	\$34.0M	\$50.5M	\$95.9M
Public hospital funding	-\$217.3M	-\$260.5M	-\$133.4M	-\$1.16B	-\$1.77B
PBS co-payments	-\$145.4M	-\$307.1M	-\$367.2M	-\$449.3M	-\$1.27B

1 Royal Australian College of General Practitioners, *RACGP Overview of the Federal Budget 2014-2015 (Health)*, 13 May 2014, p. 1.

Patient co-payments and access to healthcare

2.3 The government argues that the Medicare Benefits Schedule (MBS) is unsustainable.² The government has stated that a \$7 co-payment will reduce presentations at GPs by 1 per cent.³ The Abbott Government has also argued that the \$7 co-payment is necessary to make Medicare sustainable but the government's claim of an unsustainable MBS was consistently rejected by witnesses.⁴ Witnesses also argued that if the government's proposed \$7 co-payment is introduced, the revenue raised will not be returned to Medicare, but siphoned off to the yet to be established Medical Research Future Fund.

2.4 As announced in the 2014-15 Budget, from July 2015, the government plans to introduce a \$7 co-payment on all bulk-billed GP consultations, out-of-hospital pathology and diagnostic imaging services. All Australians including concession card holders and children will also pay the fee, capped to the first ten services. Of this, \$5 of every \$7 will go to the proposed Medical Research Future Fund.⁵

2.5 Also part of the government's healthcare Budget measures is an increase to the current Pharmaceutical Benefits Scheme (PBS) co-payment. The increased PBS co-payment will add an extra \$5 towards the cost of each PBS prescription from July 2015. Concession card holders will pay an extra 80 cents.⁶

2.6 The PBS co-payment and the \$7 co-payment have been heavily criticised. Nevertheless, the government is currently attempting to negotiate the passage of these co-payments. The committee explores the concerns raised about the passage of patient co-payments in Chapter 3 of this report.

Closure of Medicare Locals

2.7 The government has indicated it will close 61 Medicare Locals and establish a new system of 30 Primary Health Networks. This decision was outlined in the 2014-15 Budget.

2 See for example, the Hon Peter Dutton MP, Minister for Health, *Address to CEDA Conference*, 19 February 2014.

3 Mr Richard Bartlett, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 8 October 2014, p. 56.

4 See for example Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, p. 26. Also see paragraphs 3.10–3.18 below.

5 Medicare Benefits Schedule — introducing patient contributions for general practitioner, pathology and diagnostic imaging services, 2014-15 Budget, *Budget Paper 2; Budget Measures*, pp 133–134.

6 Medicare Benefits Schedule—introducing patient contributions for general practitioner, pathology and diagnostic imaging services, 2014-15 Budget, *Budget Paper 2; Budget Measures*, pp 133–134. The \$5 increase to the PBS co-payment will increase the maximum patient contribution from \$37.70 to \$42.70 from 1 January 2015.

2.8 In its hearings to date the committee has spoken to 14 Medicare Locals as well as to numerous individuals and organisations that are associated with Medicare Locals or benefit from their work. The significant concerns voiced about the closure of Medicare Locals is a key focus of this report and are the subject of discussion in chapters 4 to 6.

Abolition or merger of health care agencies

2.9 The 2014-15 Budget outlined the government's intention to abolish, merge, or consolidate agencies.⁷ Among the agencies to be abolished were Health Workforce Australia and the National Preventative Health Agency. Legislation to abolish Health Workforce Australia passed on 22 September 2014; legislation to abolish the Australian National Preventative Health Agency (ANPHA) was defeated in the Senate on 25 November 2014.⁸ However, in anticipation of the passage of the legislation, the government incorporated ANPHA's functions and staff into the Department of Health.⁹ The 2014-15 Budget allocated no funding for ANPHA past June 2014, and labelled the abolition of the ANPHA as a measure to 'achieve savings of \$6.4 million over five years from 2013-14'.¹⁰ According to the government, any savings achieved through the abolition, merger, or consolidation of agencies will be directed to the Medical Research Future Fund. At the time of writing, no legislation to establish the Medical Research Future Fund has been introduced into either house of the Parliament.¹¹

2.10 The funding for these organisations has been cut and the remaining funds will be redirected:

- funding for the Australia National Preventative Health Agency is to be invested in the Medicare Research Future Fund;¹² and
- reduced funding for Health Workforce Australia is to be directed to the Health Workforce Fund.¹³

7 The abolition, merger, and consolidation of agencies was a recommendation of the National Commission of Audit on the argument that it would create efficiency and remove duplication. The list of agencies to be abolished, merged or consolidated is at Budget Paper No. 2 – Budget Measures, Cross Portfolio, 'Smaller Government – additional reductions in the number of Australian Government bodies', p. 70.

8 *Journals of the Senate*, 25 November 2014, p. 1848.

9 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, p. 48.

10 'Smaller Government – Australian National Preventative Health Agency – abolish' Budget Measures 2014-15 – Part 2, p. 145.

11 See also paragraphs 2.16–2.18 and 3.50–3.52.

12 'Smaller Government – Australian National Preventative Health Agency – abolish' Budget Measures 2014-15 – Part 2, p. 145.

2.11 The Department of Health is to deliver the functions of the agencies with reduced funding.¹⁴ There is no information available, despite numerous questions to both the Department of Health and Treasury, as to how much funding will be available from the Department of Health's budget for the functions of health workforce planning and preventative health initiatives. A number of witnesses identified the loss of these agencies, particularly the National Preventative Health Agency, as a major issue.¹⁵

2.12 The 2014-15 Budget also counted amongst its "savings" the merger of the Organ and Tissue Authority (OTA) and the National Blood Authority (NBA). The 2014-15 Budget stated that work would begin on the merger later in 2014, with the new single authority to commence mid-2015, depending on the passage of legislation. The committee's examination of the merger between the OTA and the NBA is the subject of Chapter 7 of this report.

Reduced indexation of hospital funding

2.13 The government proposes to introduce changed indexation arrangements for public hospitals of CPI plus population growth from 2017-18. The government has also removed funding guarantees for public hospitals.¹⁶

2.14 Given that this represents a more than \$50 billion reduction in funding,¹⁷ the indexation of hospital funding is an area which the committee will continue to examine throughout its inquiry. The issue will be especially pertinent after the 2015-16 state and territory budgets have been handed down, as these will show the measures taken to address the significant shortfall in funding due to the reduced indexation of hospital funding, by the federal government. While most state government departments have not participated in the committee's inquiry to date, the evidence taken in South Australia reveals the impact of these cuts. This issue is discussed towards the end of Chapter 3.

13 'Smaller Government – More Efficient Health Workforce Development', Budget Measures 2014-15 – Part 2: Expense Measures, p. 146.

14 See both: 'Smaller Government – Australian National Preventative Health Agency – abolish' Budget Measures 2014-15 – Part 2, p. 145; and 'Smaller Government – More Efficient Health Workforce Development', Budget Measures 2014-15 – Part 2: Expense Measures, p. 146.

15 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.

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

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

Medical Research Future Fund

2.15 The government announced in the Budget a plan to establish a \$20 billion Medical Research Future Fund (MRFF), claiming that 'every dollar of savings from health in this Budget will be invested to build this Fund, until the Fund reaches \$20 billion.'¹⁸

2.16 Legislation to establish the MRFF is listed for introduction in the 2014 Spring Sittings. However at the time of writing the government claims that the establishment of the fund will also hinge on the passage of the co-payment legislation.¹⁹ Some savings, such as those from the removal of the National Health Reform Agreements, will be available sooner for investment in the fund. Discussion of the merits of the MRFF has arisen in public hearings due to its link to the \$7 co-payment. While many saw a future increase in funding for medical research to be positive, most were concerned that it was to be funded in a way which would increase inequity in access to healthcare,²⁰ and which asks the chronically ill to bear the greatest cost burden.

2.17 As the government is yet to announce the details of the MRFF, this issue is only considered in this interim report in the context of the linkage to the \$7 co-payments. However, the MRFF is an area which the committee will continue to examine throughout its inquiry.

Mental health

2.18 Mental health consumers need to draw on the services of preventative, primary, and where needed hospital health care. A number of witnesses argued that mental health, already often neglected in terms of resourcing, will be further disadvantaged by the 2014-15 Budget cuts to health funding.²¹ While not discussed specifically in this interim report, mental health is an area which the committee will continue to examine throughout its inquiry.

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

19 Department of the Prime Minister and Cabinet, *Legislation Proposed for Introduction in the 2014 Spring Sittings*, www.dpmc.gov.au/parliamentary/docs/legislation_proposed_2014_spring_sittings.pdf?d=20140821.

20 See evidence from Professor Mike Daube, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; and Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, 10 October 2014, p. 24; and Professor Judith Walker, Chair, Federation of Rural Australian Medical Educators, *Committee Hansard*, 7 October 2014, p. 35.

21 See for example evidence from Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ, *Committee Hansard*, 21 August 2014, p. 12.

Health prevention, promotion and education

2.19 Preventative health, health promotion and health education have also been themes raised at many of the committee's hearings and in a large number of submissions received.²² Organisations in the preventative health sector have voiced concerns not only about the abolition of the ANPHA, but also of the detrimental effect that the PBS and \$7 co-payments will have on preventative health. Towards the end of Chapter 3, the committee explores the government's proposal to abolish ANPHA.

2.20 The committee has frequently heard the argument that the patient co-payment will dissuade people from seeking primary healthcare, as the \$7 co-payment applies to GP consultations, out-of-hospital pathology and diagnostic imaging services. As a result medical conditions which are able to be treated early or managed effectively are likely to be left untreated, leading to more interventionist hospital treatment and a greater expense to the state health system. Health prevention, promotion and education are areas which the committee will continue to examine throughout its inquiry.

Interim Report outline

2.21 This Interim Report is the first of the series of interim reports with which the committee will mark its progress in its inquiry. The committee expects to table an interim report on different subject matters approximately twice a year.

2.22 This report's main purpose is to explore the key issues so far identified by the committee's work. In particular, the report will examine:

- the proposed \$7 co-payments relating to GP visits, pathology, and diagnostic imaging and pharmaceutical medicines; cuts to hospital funding; and the abolition of ANPHA (Chapter 3);
- the abolition of 61 Medicare Locals and the establishment of 30 PHNs (Chapter 4); and
- the proposed merger of the OTA and the NBA (Chapter 5).

Committee comment

2.23 The committee feels that this interim report is timely. The negative impacts of the healthcare changes which the government initiated in the 2014-15 Budget are now becoming apparent. Yet despite overwhelming evidence of deep concern over the government's policies, work is continuing in areas such as the closure of Medicare Locals; the implementation of a \$7 co-payment and an increased PBS co-payment; and cuts to hospital funding, to name just a few.

22 See for example: Australian Diabetes Educators' Association, *Submission 49*; Victorian Health Promotion Foundation (VicHealth), *Submission 80*; and Australian Health Promotion Association, *Submission 84*.

2.24 By international standards, Australia has a quality healthcare system which provides a high standard of care to all Australians regardless of income. The challenges faced by the Australian healthcare system include access, particularly in regional and rural areas; further recognition of the role of health prevention and education; workforce planning; and the use of emerging technologies. The government's claim that the healthcare system is unsustainable is considered in detail in paragraphs 3.10 to 3.18.

2.25 The issues examined in this report are those which, in the committee's opinion, are the most immediate and which demonstrate the need for a wholesale rethink of government policy.

Chapter 3

Patient co-payments, cuts to hospital funding and preventative health

Introduction

3.1 During the committee's inquiry one issue has dominated the evidence: concern over the \$7 co-payment. This chapter will examine the concerns raised about the proposed \$7 co-payment.

3.2 As discussed in chapter 2, from July 2015, the government will introduce a \$7 co-payment on all bulk-billed GP consultations, out-of-hospital pathology and diagnostic imaging services. The government also plans to increase the current Pharmaceutical Benefits Scheme (PBS) co-payment by an extra \$5 for each PBS prescription for non-concession card holders from July 2015. Concession card holders will pay an extra 80 cents.

3.3 The committee notes that this policy area has recently been the subject of a Senate Community Affairs References Committee inquiry and report into out-of-pocket healthcare expenses.¹ That report, *Out-of-pocket costs in Australian healthcare*, was tabled on 22 August 2014 and provides a useful summary of the information known about the proposed co-payment post the 2014-15 Budget. As there has been minimal new information released by the government about the PBS and \$7 co-payments since the May Budget, the committee reproduces parts of the background information from that report below.

Background—patient co-payments²

3.4 At the time of writing the government continues to assert that from 1 July 2015, bulk-billed patients will be required to pay \$7 per visit toward the cost of GP consultations, and out-of-hospital pathology and imaging services. Under the proposed changes, \$5 will be invested in the Medical Research Future Fund and \$2 will be paid directly to the doctor or service provider. Medicare rebates for items attracting a patient contribution will be reduced by \$5.

3.5 The government has indicated that doctors will be paid a 'low gap incentive payment' to encourage them to charge concession card holders and children under 16

1 Senate Community Affairs References Committee, *Out-of-pocket costs in Australian healthcare*, August 2014, www.apf.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Australian_healthcare (accessed 3 November 2014).

2 Much of this section of the report is reproduced directly from the Senate Community Affairs References Committee, *Out-of-pocket costs in Australian healthcare*, August 2014, pp 25–27.

no more than a \$7 "contribution" for their first 10 visits, and to bulk-bill these patients (after 10 initial visits) and not charge them for subsequent visits.

3.6 Currently, the incentive payment for bulk-billing concession patients is \$6 for metropolitan areas and \$9.10 for regional areas and Tasmania. GPs do not receive an incentive payment when bulk-billing patients without a concession card.

3.7 In the Budget, the government also announced that from 1 January 2015, general patients will pay an extra \$5.00 towards the cost of each PBS prescription. Patients with a concession card will pay an extra \$0.80 towards the cost of each PBS prescription.³

3.8 Following the tabling of the 'out-of-pocket' report, there has been continued critical commentary on both types of co-payment proposals. During the same period there has been no new information from the government about the policy itself. The committee observes that across its broad remit of health portfolio matters, a key concern of witnesses has been the serious and harmful effects of this policy, particularly the \$7 co-payment.

Policy development

3.9 Three key themes emerged from the evidence presented to the committee regarding the government's policy development process:

- the \$7 co-payments were based on an assertion by the government of an unsustainable healthcare system—in particular that expenditure on the MBS was not sustainable;
- the \$7 co-payments proposal was not based on credible evidence; and
- the government did not consult stakeholders during the policy development process.

Sustainability

3.10 Both before and after the May 2014 Budget the government has claimed that Australia's healthcare system is unsustainable. For instance the Health Minister, the Hon Peter Dutton MP, stated at the February 2014 CEDA Conference that the health budget was 'tracking on an unsustainable path with no prospect of meeting the needs of the health of our nation in the 21st century.'⁴

3.11 Post-Budget, in September 2014, the Health Minister told *Lateline*:

We're determined to make sure that Medicare is sustainable into the 21st Century. We've got an ageing population, huge costs coming down the line. The fact that we spend \$20 billion today on Medicare, but only raise about

3 Department of Health, *Portfolio Budget Statements 2014-15*, Budget Related Paper No. 1.10, p. 63.

4 The Hon Peter Dutton MP, Minister for Health, *Address to CEDA Conference*, 19 February 2014.

\$10 billion from the Medicare levy and the gap grows and grows each year. It's absolutely necessary that we introduce sensible reforms...⁵

3.12 This notion of unsustainability has repeatedly been cited as the rationale for the government's \$7 co-payment policy intervention. However, the evidence provided to the committee does not support the government's assertions. For example the AMA's submission states that:

The Government is justifying the health budget measures on the basis that Australia's health spending is unsustainable. It is not.

- Health is 16.13% of the total 2014-15 Commonwealth Budget, down from 18.09% in 2006-07.
- Health was 8.9% of Australia's GDP in 2010, stable when compared with 8.2% in 2001, and lower than the OECD average of 9.3%.

The Government fails to acknowledge that Australia's nominal GDP continues to grow at rates that are above OECD averages. Australia can afford the health system it currently has.⁶

3.13 The College of Medicine and Dentistry, James Cook University pointed out that general practice is not driving force in any increase in MBS expenditure:

There is concern about a rise in health care costs driven by an increase in Medicare spending. Further analysis suggests that most of the increase in spending has come from an increase in specialist and hospital spending and from areas such as pharmaceuticals and medical imaging (ie. New, improved and more spending per person). Productivity commission figures indicate that in 2012-13 Australian Government expenditure on general practice was \$286 per person, but in the same period government spending on public hospitals was \$1792 per person. General practice is not the cost driver in the Medicare Benefit Scheme (MBS).⁷

3.14 The Australian Medical Association Victoria supported the view that health expenditure is not unsustainable:

Whichever set of numbers you want to look at, we can look at the percentage of the Commonwealth budget, in terms of health. We have said that it was 18 per cent and it is down to 16 per cent. On that measure alone it is not unsustainable. If we look at general practice, in this whole co-payment argument general practice has been hit over the head with a very big stick as being to blame for the problem, but nothing could be further from the truth. In fact, general practice is the solution to the problem, not the problem.⁸

5 The Hon Peter Dutton MP, Minister for Health, *Lateline*, 8 September 2014.

6 Australian Medical Association (AMA), *Submission 48*, p. 4.

7 College of Medicine and Dentistry, James Cook University, *Submission 17*, p. 5.

8 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 43.

3.15 Associate Professor Sarah Larkins who is the Director of Research and Postgraduate Education at the College of Medicine and Dentistry, James Cook University cited Productivity Commission analysis to demonstrate that primary care is not driving healthcare expenditure:

'Productivity Commission figures suggested in 2012 and 2013 that Australian government expenditure on general practice is around \$304.10 per person but in the same period government spending on public hospitals was \$1,792 per person thus general practice spending is 15.5 per cent of the total government spending. General practice is not the cost driver in the [Medicare Benefits Schedule].⁹

3.16 While acknowledging that healthcare expenditure is rising gradually over time, Dr Stephen Duckett, Director of the Health Program at the Grattan Institute, explained that Australia's healthcare system is not unsustainable and that increased investment in healthcare is often a deliberate choice made by wealthy countries:

Australia...is one of the better performing health systems in the world. In terms of health expenditure, for example, we are below the comparable OECD average in terms of share of GDP and cost per capita. That is not to say that we should not be doing something. I am not one who thinks the health system is unsustainable. We have seen an increase in its share of gross domestic product over time; in fact, it is projected to increase [from approximately 9 per cent] to a bit over 12 per cent of GDP over the next 20 or so years. That does not mean it is unsustainable. What it does mean is that we have to think about what it is that we are going to trade off, what it is that we are going to give up, and whether that is what we want. Basically all wealthy countries spend more on health care as they get wealthier; it is a choice that society makes, that we want to invest in health care.¹⁰

3.17 Finally on this point the committee notes that, contrary to the Health Minister's argument about unsustainable health funding, the Australian Institute of Health and Welfare (AIHW) report *Health expenditure Australia 2012-13* states that health funding in that year had in fact decreased:

Expenditure on health in Australia was estimated to be \$147.4 billion in 2012–13, 1.5% higher than in 2011–12 and the lowest growth since the mid 1980's. In 2012–13, governments provided \$100.8 billion (or 68.3%) of total health expenditure. Government funding of health expenditure fell in real terms for the first time in the decade by 0.9%, largely a result of a decline in Australian Government funding of 2.4%. State and territory government funding was also relatively low, growing just 1.4% in real

9 Associate Professor Sarah Larkins, Director of Research and Postgraduate Education, College of Medicine and Dentistry, James Cook University, *Committee Hansard*, 21 August 2014, p. 19.

10 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, p. 26.

terms in 2012–13. In contrast, growth in non-government funding was relatively strong at 7.2%.¹¹

Committee comment

3.18 The committee considers that the government's argument that the MBS is unsustainable is not supported by the witness testimony or submissions. The AIHW report also reveals the fallacy of the government's claims.

\$7 co-payment not supported by modelling

3.19 During the Senate Community Affairs References Committee's out-of-pocket expenses inquiry, the Department of Health explained that it produced 'estimates', not 'modelling' for the government of two academic papers, the RAND study and the Keel and Hillberg paper. The latter paper is a meta-analysis of a 'range of co-payments which have been introduced in a variety of countries around the world and what their effects have been'. The department did recognise that each health system is unique, and that the Australian system is quite unique, as are some of the issues it faces,¹² which calls into question the application of the papers' findings to an Australian policy context. Further, the Department also admitted that '[it] did not make estimates about impacts [of \$7 co-payments] on emergency departments.'¹³

3.20 The committee is surprised at the Department's use of papers analysing overseas jurisdictions as evidence of modelling having been undertaken for the introduction of the \$7 co-payments. Given the uniqueness of the Australian health system, it is surprising that overseas models are being used, especially given the Department's own admission that it had not undertaken modelling of the compounding effects of the \$7 co-payment on emergency departments. The impacts on NSW and South Australia's emergency departments are detailed below.

Co-payments—ideologically driven and not evidence-based

3.21 The committee heard evidence that the government's proposed \$7 co-payment and the increased PBS co-payment were not based on credible evidence. The policy originates from Mr Terry Barnes, a former policy adviser to the Hon Tony Abbott MP when the Prime Minister was Health Minister and later Opposition Leader. It was picked up by the government's National Commission of Audit and subsequently adopted by the government in the 2014-15 Budget. It was described by its author as 'sending a price signal to people, there's no doubt about that... the level of co-payment

11 AIHW, *Health expenditure Australia 2012-13*, 23 September 2014, www.aihw.gov.au/publication-detail/?id=60129548871.

12 Mr Bartlett, Department of Health, *Senate Community Affairs References Committee Out-of-pocket costs in Australian healthcare inquiry*, *Committee Hansard*, 29 July 2014, p. 58.

13 Mr Bartlett, Department of Health, *Senate Community Affairs References Committee Out-of-pocket costs in Australian healthcare inquiry*, *Committee Hansard*, 29 July 2014, p. 59.

we're suggesting is equivalent to a hamburger and fries or a schooner of beer, it's not a great deal.¹⁴

3.22 However the AMA, amongst others, has criticised the policy 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.¹⁵

3.23 This view was supported by submitters such as the Queensland Nurses' Union, which stated:

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.¹⁶

No consultation

3.24 The committee was consistently told that the government had either failed to, or deliberately avoided consulting on the \$7 co-payments prior to their announcement in the 2014-15 Budget. The following organisations/sectoral interests confirmed that the government had not consulted with them prior to Budget night:

- Australian Medical Association Tasmania¹⁷
- Royal Australian College of General Practitioners¹⁸
- Royal Australasian College of Physicians¹⁹
- The Hon. Jay Weatherill, Premier, South Australian Government²⁰

14 Mr Terry Barnes, Australian Centre for Health Research, *Former Abbott adviser flags possible fees to visit hospital emergency wards*, ABC website, 30 December 2013, www.abc.net.au/news/2013-12-30/emergency-room-fee-to-match-doctors-fees/5178156 (accessed 3 November 2014).

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

16 Queensland Nurses' Union, *Submission 44*, p. 3.

17 Associate Professor Timothy Moore Greenaway, State President, Australian Medical Association Tasmania, *Committee Hansard*, 3 November 2014, p. 37.

18 Dr Bastian Seidel, Deputy Chair, Tasmanian Faculty, Royal Australian College of General Practitioners, *Committee Hansard*, 3 November 2014, p. 19.

19 Professor Nicholas Talley, President, Royal Australasian College of Physicians, *Committee Hansard*, 8 October 2014, p. 8.

20 The Hon. Jay Weatherill, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 3.

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- The Grattan Institute²¹
 - Australasian College of Emergency Medicine²²
 - Australian Diagnostic Imaging Association²³
 - Residential aged care²⁴
 - Ambulance Employees Australia of Victoria²⁵
 - Australian Nursing and Midwifery Federation (SA Branch)²⁶
 - Aboriginal Health Council of South Australia²⁷
 - Health Consumers Alliance of South Australia²⁸

Minimal modelling of impact on disadvantaged and young Australians

3.25 The committee is particularly concerned at the lack of data or modelling from the Department of Health relating to the numbers of eligible concession card holders and under 16 year olds who would not be liable to pay the \$7 co-payment after 10 visits. The complicated system of visit caps and patient co-payments has demonstrated that the Department of Health either has no data to clearly explain the proportion of the Australian population that would pay the \$7 co-payment for the first 10 visits or is refusing to release it.

3.26 In Senate Estimates hearings, the Department of Health was asked to quantify the total number of concession card holders who will meet the cap:

There were 7.8 million people who had a concession card at any time during the 2012-13 financial year who had at least one Medicare service in that year. Of these people, 3.1 million (40 per cent) had more than 10 in-scope services (that is, out-of-hospital services for which the patient

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- 21 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, p. 35.
- 22 Dr Simon Antony Judkins, Victorian Councillor, Australasian College of Emergency Medicine, *Committee Hansard*, 8 October 2014, p. 23.
- 23 Ms Pattie Beerens, Chief Executive Officer, Australian Diagnostic Imaging Association, *Committee Hansard*, 8 October 2014, p. 43.
- 24 Mr Stephen Burgess, Innovation, Policy and Research Officer, Benetas, *Committee Hansard*, 7 October 2014, p. 11.
- 25 Mr Danny Hill, Assistant Secretary, Ambulance Employees Australia of Victoria, *Committee Hansard*, 7 October 2014, p. 19.
- 26 Adjunct Associate Professor Elizabeth Dabars, AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, 9 October 2014, p. 32.
- 27 Mr Shane Mohor, Acting Chief Executive Officer, Aboriginal Health Council of South Australia, *Committee Hansard*, 9 October 2014, p. 45.
- 28 Ms Stephanie Miller, Executive Director, Health Consumers Alliance of South Australia, *Committee Hansard*, 9 October 2014, p. 65.

contribution measure applies). Some of these services are not currently bulk billed.²⁹

3.27 The committee is disappointed that the Department was unable to provide detailed modelling of the expected numbers of patients who would be required to pay the \$7 co-payment following its introduction.

Committee comment

3.28 Given that this was to be a government of no nasty surprises,³⁰ it is of great concern that a policy of the scale and impact of that proposed in the \$7 co-payment was done without consultation with consumers of the healthcare sector and was not revealed to the Australian public prior to the 2013 election.

Negative impacts

3.29 Witnesses' concerns about the negative impacts of the \$7 co-payments and the increased PBS co-payment were a regular feature of the evidence put before the committee. They can be divided into the following five areas:

- 1) **Undermining universality** – the diminution of the principle on which universal healthcare and Medicare is based.
- 2) **Inequity** – concern that the patient co-payments will be detrimental to the health and life opportunities of the most vulnerable sections of the Australian community.
- 3) **Economic** – cost shifting to the states via increased emergency department visits and public hospital admissions as well as cost shifting to the Australian community through payment of the patient co-payments. Concerns were also raised about the potential for the patient co-payments to lead to higher system-wide healthcare costs as a result of increased reliance on highly expensive hospital treatment over more cost-effective primary care.
- 4) **Health prevention and management** – that the patient co-payments will delay or prevent people seeking primary healthcare from GPs, pathology and imaging specialists, and by filling prescriptions and thus fail to treat preventable illnesses or make early interventions. Concerns were also raised that the patient co-payment would impose additional cost burden on patients managing chronic disease, leading to worse health outcomes.
- 5) **Administration** – how the \$7 co-payment will operate in practice; what services will attract the co-payment; how can it be collected; additional costs for administration and collection of the co-payment on GPs and other health providers.

29 Answer to Question on Notice, Senate Community Affairs Legislation Committee, Budget Estimates 2014-15, SQ14-000985, p. 1.

30 www.smh.com.au/business/federal-budget/abbott-pledges-no-nasty-surprises-no-lame-excuses-20130516-2jpen.html (accessed 20 November 2014).

- 6) **Links to the Medical Research Future Fund** – widespread support for increased investment in medical research but not via the proposed \$7 co-payment.

Undermining universality

3.30 The risk posed by the government's proposed patient co-payments to Australia's system of universal healthcare was a grave concern to many submitters. The St Vincent de Paul Society explained to the committee the government's obligation to provide universal healthcare:

...there is an internationally recognised right to health. Moreover, Australia has ratified international human rights treaties which include sustaining this right. The provision of universal healthcare therefore plays an important component of our government's legal, moral, and social responsibility to its citizens. The Medicare system has been providing this universal healthcare for decades, which has gone a long way in preventing major health disparity in our communities. This has been particularly important for those who are socioeconomically disadvantaged or marginalised, and who cannot afford alternative (private) health services.³¹

3.31 The Public Healthcare Association of Australia raised similar concerns:

Universal access to primary health care based on need and not on the ability to pay is a fundamental human right. Providing access to primary health care is an essential role of Government and not a cost that can be shifted onto those in the community who least can afford to pay.³²

Inequity

3.32 Closely linked to the question of universality of healthcare coverage is the inequity in access to healthcare for disadvantaged sections of our society.

3.33 An official from the South Australian Department of Health and Ageing effectively summarised the concerns expressed by many witnesses about the disproportionate impact the \$7 co-payment will have on Australia's most vulnerable:

South Australia is significantly concerned about the disproportionate detrimental impact the co-payments will make on the most vulnerable people in the community, particularly Aboriginal and Torres Strait Islanders, older people, those with low socioeconomic status and those with chronic conditions needing primary management in order to avoid hospital. It is concerning that these at-risk patients may see the co-payment, in particular, as a prohibitive barrier and be discouraged from seeing their doctor or filling their prescriptions. In turn, these conditions could worsen or place increasing pressure on our hospitals but also impact on quality of life and health outcomes.³³

31 St Vincent de Paul Society, *Submission 22*, p. 3.

32 Public Health Association of Australia, *Submission 76*, p. 8.

33 Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 4.

3.34 The Dieticians Association of Australia (DAA) provided a starting point for the categories of vulnerable communities that will have their access to healthcare diminished by the \$7 co-payment:

DAA is concerned that additional costs will further disadvantage vulnerable groups in the community. People experiencing socioeconomic difficulties, Indigenous Australians, people living with mental illness, people with disability, and rural and remote residents shoulder a greater chronic disease burden. Yet they have poorer access to comprehensive healthcare through Medicare with a limit of five face-to-face allied health visits under MBS Chronic Disease items per year.³⁴

3.35 Similarly, ACOSS provided this overview of the types of groups that will experience further access issues because of the proposed \$7 co-payments:

We are also concerned that proposals may further disadvantage groups in the community that already are not sharing in the good health experienced by most Australians. Particular groups in the community including Aboriginal and Torres Strait Islander communities, those with chronic illnesses, and people with disabilities and mental health issues need to be supported to access the services they need, rather than facing additional barriers to access.³⁵

3.36 Benetas, as a large provider of aged care services supporting over four thousand older people requiring aged care, noted there were significant issues with the imposition of a \$7 co-payment on the ability of older Australians to obtain advice and treatment for medical conditions. Benetas's submission noted:

Older people consistently identify access to affordable and quality health care services as an area of concern. Chronic disease and poorer health status preferentially affects those on the lowest incomes and those that live in areas of concentrated disadvantage.³⁶

3.37 Benetas argued that older people with multiple chronic medical conditions should be encouraged to seek primary medical care, as early treatment and management would reduce admissions for acute hospital care.³⁷ This would result in significant savings to the Commonwealth, and corroborates evidence from multiple witnesses that preventative health programs are effective in reducing both hospital admissions and costs.

3.38 Organisations representing young people also raised objections to the introduction of the \$7 co-payment, suggesting that the government's cost cutting agenda would further disadvantage young people, who already experience significant cost barriers to obtaining medical care:

34 Dieticians Association of Australia, *Submission 59*, p. 2.

35 Australian Council of Social Service, *Submission 67*, p. 2.

36 Benetas, *Submission 42*, p. 2.

37 Benetas, *Submission 42*, p. 2.

YACSA [Youth Affairs Council of South Australia] strongly opposes the government's transparent cost-cutting agenda as set out in the 2014 budget. The changes proposed by the Federal Government including the Medicare and PBS medications co-payments, if undertaken in the current and proposed income and social service support environment, has the potential to increase disadvantage and negative health impacts amongst already vulnerable young people.³⁸

3.39 The National Aboriginal Community Controlled Health Organisation (NACCHO) also argued for more investment in preventative treatments, arguing benefits to Aboriginal and Torres Strait Islander people would be significantly enhanced through the provision of comprehensive primary health care. Its submission also strongly opposed the imposition of additional cost barriers to accessing medical services, arguing:

...the form of a GP co-payment and a rise in the cost of accessing PBS medicines...would discourage Aboriginal and Torres Strait Islander patients seeking preventative health care and proactively managing chronic disease.³⁹

3.40 NACCHO noted that Aboriginal and Torres Strait Islander people already delay GP treatment for preventable illness. This trend was expected to worsen if the government proceeded with a \$7 co-payment:

On average 12 per cent of Aboriginal Australians defer GP visits for more than a year because of costs. This is more than twice the rate of the general population. Aboriginal Australians also represent a disproportionately high number of 'potentially avoidable GP-type presentations' to hospital outpatient centres, particular in major cities and inner regional centres. Additional costs to accessing healthcare [a \$7 co-payment] would result in further delays to seeking care, resulting in greater health risks to patients.⁴⁰

3.41 The Aboriginal Health Council of South Australia supported the arguments made by NACCHO. Mr Shane Mohor, Acting Chief Executive Officer of the Aboriginal Health Council of South Australia told the committee that the \$7 co-payment would have severe flow on effects across the whole community:

When we look at the current health status of our community we are at the lowest end of the margin and by not accessing GPs and by not seeking preventative health care, you are going to increase the rates of illnesses and morbidity and mortality rates will increase. So there are significant flow-on effects...The impact that this will have on the youth right across Australia, whether you are Aboriginal or not, is an unforeseen example of not a measured response to a budget cut which could see youth crime increase to pay for a GP visit. It will potentially have non-adherence to medication or prescribed medication based on the cost...We already have elderly who are

38 Youth Affairs Council of South Australia Inc, *Submission 38*, p. 2.

39 National Community Controlled Health Organisation, *Submission 86*, p. 3.

40 National Community Controlled Health Organisation, *Submission 86*, pp 4–5.

noncompliant with medications because they forgo their medications to provide food and clothing to their grandchildren, as opposed to going to a GP for their own medical problems.⁴¹

3.42 The Aboriginal Health Council of Western Australia argued strongly for the government not to implement the \$7 co-payment:

For a government who has repeatedly made verbal expressions of commitment to improving the health and living standards of Australia's Aboriginal people, such budget changes not only fail to reflect these expressed commitments, but will lead to catastrophic outcomes for Australia's first people. AHCWA urges the federal government to recognise its obligations under internationally recognised human rights conventions, to which it is signatory, and to work closely with Aboriginal communities and service providers, particularly ACCHS, to close the unforgiving gap between the health outcomes of Aboriginal and other Australians.⁴²

3.43 While noting that access to health services is a human right, St Vincent de Paul Society submitted that research into social determinants of health has concluded that health outcomes are often closely intertwined with socio-economic status.⁴³ Its submission noted:

Increasing the cost of healthcare must also be seen against the background of other financial pressures on the most disadvantages. Housing affordability is decreasing, income support payments from the government are decreasing (either directly or due to lack of indexation), the cost of education is increasing, and utility prices are increasing far above inflation. Adding further barriers to healthcare will not just add to, but will compound, these issues. The costs will be severely detrimental to the wellbeing of those who are already doing it tough.⁴⁴

3.44 The Australian Federation of AIDS Organisations (AFAO) argued that Australians living with HIV/AIDS would also be disadvantaged by the introduction of cost barriers to medical care services. AFAO's submission argued that the \$7 co-payment would undermine years of work undertaken by previous Federal and State Governments in formulating a comprehensive and effective response to blood borne viruses in Australia:

The introduction of any new mandatory healthcare co-payments and the increase of any current healthcare co-payments would undermine prevention efforts by imposing perceived or real cost barriers to testing for HIV (and for other BBVs and STI tests). Initiatives to address barriers to accessing testing services and thereby enhance HIV testing rates and frequency have been carefully framed over the last few years, under the

41 Mr Shane Mohor, Acting Chief Executive Officer of the Aboriginal Health Council of South Australia, *Committee Hansard*, 9 October 2014, pp 44–45.

42 Aboriginal Health Council of Western Australia, *Submission 63*, p. 13.

43 St Vincent de Paul Society, *Submission 22*, p. 2.

44 St Vincent de Paul Society, *Submission 22*, p. 4.

Sixth HIV Strategy and enhanced under the new Strategy [2014-17], with Commonwealth resources committed to the rollout of rapid HIV testing services in community settings for gay men and other men who have sex with men. Essential to marketing these services is that they are free of charge; any perception that the introduction of mandatory co-payments would mean that all BBV and STI tests would incur a co-payment would necessarily undermine these efforts.⁴⁵

3.45 For Australia's most vulnerable groups, there are already numerous barriers to accessing healthcare. The committee consistently heard evidence that the \$7 co-payment and the increased PBS co-payment would add an additional damaging cost barrier and act as a disincentive for people to seek medical assistance and to access medicines under the PBS. For instance Mr Bonner, the Director of Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch), argued that Australia was already behind other countries in terms of healthcare costs impacting on disadvantaged groups:

The Commonwealth Fund study [*How the Performance of the U.S. Health Care System Compares Internationally*] showed that Australia was the third worst of the 11 countries in the study. [Australia] ranked only really behind the US and the Netherlands in relation to prescription costs impacting on low-income people. So this idea that we need to put more costs into the system to disincentivise people from unnecessarily taking drugs or turning up at GP services is just clearly a nonsense because we are already up there amongst the most highly hit for co-payments, whether you are talking about scripts, GPs or other tests...

It is frightening when you think that one in six people of below-average income is skipping, already, some or all of their prescription medications. If you are getting that level of noncompliance now, what would that look like if you increased by another \$7 the level of the price of each of those scripts?⁴⁶

3.46 The perspective from Victoria's frontline of hospital care, the Ambulance Employees Australia (Victoria), was that disadvantaged groups would be the first to be negatively affected by the \$7 co-payment and this would result in a reliance on hospital care rather than less costly primary care:

So much of paramedics' work is [generated] because patients feel they do not have any other alternative. It could be that they perhaps do not understand the system. People of limited English may not understand the health system and what is available to them. They do not understand about preventive care and things like that. As I said, we need to see people being comfortable and having GPs and other health providers more accessible to people, particularly in low socioeconomic areas. There needs to be a way of

45 Australian Federation of Aids Organisations, *Submission 108*, p. 2.

46 Mr Rob Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, 9 October 2014, p. 34.

bringing people into the system, trusting the system and building up that trust. To me, the co-payment just puts another barrier in front of that.⁴⁷

Negative economic impacts

3.47 The government has stated its intention in introducing the \$7 co-payments is to create a 'price signal' to reduce the number of visits to GPs and for out-of-hospital pathology and diagnostic imaging services.⁴⁸ The Department of Health informed the committee that it anticipates a one per cent reduction (equivalent to approximately 1 million fewer visits) in the number of GP attendances in the first 12 months of the \$7 co-payments.⁴⁹ The committee is aware of anecdotal evidence indicating an immediate decline in GP visits following the Budget announcement due to patients' misunderstanding that the \$7 co-payment was already in force.⁵⁰

Price signals inappropriate for primary care

3.48 Experts in health economics have argued that price signals are inappropriate and ineffective in the context of primary care:

Price signals work by encouraging consumers to think about whatever it is they are about to buy, and whether it's worth the cost. They assume some consumer knowledge of the product, and its value. We rely on prices right through the economy to temper consumption.

But this economic common device 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.

Evidence from Australia and other countries shows that low-income groups are much more likely to rely on general practitioners than visit more expensive specialists. But it is this less expensive and more accessible (and accessed) service that's being targeted by the government's proposal.

The chairman of the National Commission of Audit, the treasurer and the health minister have all claimed that Australians go to the doctor too often. They suggest the introduction of a price signal for health in the form of co-payments will only reduce trivial visits.

47 Mr Danny Hill, Assistant Secretary, Ambulance Employees Australia of Victoria, *Committee Hansard*, 7 October 2014, p. 18.

48 The Hon Peter Dutton MP, Minister for Health, *Address to Australian Medical Association National Conference*, 23 May 2014.

49 Mr Richard Barlett, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 8 October 2014, p. 56.

50 ABC News, *GP co-payment proposal causing a drop in visits to the doctor, AMA says*, 23 May 2014, www.abc.net.au/news/2014-05-22/visits-to-gp-fall-after-co-payment-budget-announcement/5469642 (accessed 5 November 2014).

...Co-payments cannot operate as an effective price signal if people can't judge the quality of what they're buying. They will simply stop going if they cannot afford to pay.⁵¹

3.49 The need for price signals in primary health care has been much criticised since the \$7 co-payment was announced in the 2014-15 Budget. Ms Carter from the Victorian Medicare Action Group (VMAG) was one witness who discussed the irrationality of a price signal on access to primary health:

In terms of price indicators, it is very clear from the patterns of access to GPs that co-payments are not effective in either deterring overuse of GP services or encouraging use of necessary health services by the people who most need them. I note that the report of the Senate committee [inquiring into out-of-pocket expenses] suggests that at least six percent of the population are already deferring access to general practice because of the costs involved in accessing health care—that may not be co-payments for the GP service but other costs—and that the most marginalised, Indigenous people, are 12 percent more likely not to access general practice costs and in fact to defer them up to a year, according to the data in the [out-of-pocket expenses] report. It is a very crude instrument for dealing with the subtle nuances—and the not-so-subtle nuances, I guess—of our health system, and it is not very creative.⁵²

Cost-shifting to the states

3.50 Other witnesses argued that an unintended consequence of the \$7 co-payment would be to shift the cost of treatment from primary health to hospitals and so from the federal government to the states. This position was not declared prior to the federal election of 2013. Professor Dabars, CEO of the Australian Nursing and Midwifery Federation (SA Branch) explained that the \$7 patient co-payment would cause people to defer primary health care with the result that treatable conditions would eventually require hospital care:

...the introduction of co-payments for a range of health services—GP visits, pathology tests, radiology services—and the increases in pharmaceutical payments will, in our submission, likely lead to those people most in need of attending those services either avoiding them or delaying seeking care due to costs. In addition to the personal and unintended social and economic impacts that co-payments will have, they will add to the cost of our healthcare system over time. People avoiding visiting the GP and whose health conditions worsen will ultimately attend the hospital emergency department acutely unwell. People taking multiple medications for chronic health conditions and who become partially or wholly noncompliant with those directions again will become more unwell

51 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, <http://theconversation.com/gp-co-payments-why-price-signals-for-health-dont-work-28857>, (accessed 4 November 2014).

52 Ms Jane Carter, Spokesperson, VMAG, *Committee Hansard*, 7 October 2014, p. 3.

and require additional services. Those costs will impact the most vulnerable in our community: those on benefits or pensions, the lower paid and especially those with families, but also, research suggests, disproportionately on Indigenous people, on women, on the elderly and on those with chronic diseases such as asthma or mental health conditions.

I noticed you were talking earlier about studies that are available. There was a study undertaken by the Commonwealth Fund, reported in June 2014, [*How the Performance of the U.S. Health Care System Compares Internationally*] that in below average income households 14 per cent of people had not seen a doctor for a medical problem in the previous year, and in above average households the result was five per cent. Fourteen per cent of below average income households had avoided or skipped medications, while the figure for above average income people was eight per cent.⁵³

3.51 In a similar vein, Professor Mike Daube, Curtin University, Perth, and former head of the WA Health Department, stated:

I also note that I have concerns about the proposed co-payment scheme. Others with more expertise in that area will have spoken with you and will have made submissions. From my perspective, I have to say, firstly, I simply do not understand the rationale for it and, secondly, I have no doubt whatever that it will increase the burdens on the states and territories, everything from increased pressures on [Emergency Departments] to the flow-on there—why would you not go to an [Emergency Department] if you do not have to pay for it, you just have to wait a while?⁵⁴

3.52 Several state governments have estimated the increased pressure on emergency departments and hospital admissions resulting from the \$7 co-payments. For example a preliminary study conducted by the NSW Health Department shows an expected increase of 500 000 people visiting the state's emergency departments if a \$7 co-payment was enforced.⁵⁵ This represents a 27 per cent increase from 2.6 million presentations to NSW emergency departments in 2012-13 to approximately 3.1 million per annum once the \$7 co-payment is introduced. The committee notes that emergency department admissions can cost up to ten times that of a typical GP visit.⁵⁶

3.53 Similarly concerning figures were provided to the committee by officials from the South Australian Department of Health and Ageing:

53 Adjunct Associate Professor Elizabeth Dabars, AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, 9 October 2014, p. 29.

54 Professor Mike Daube, *Committee Hansard*, 10 October 2014, p. 21.

55 The NSW assessment was made on the earlier mooted figure of \$6 so the 500 000 figure is likely to be a conservative estimate.

56 Daily Telegraph, *NSW emergency fears due to GP co-payment*, 8 October 2014, www.dailytelegraph.com.au/news/breaking-news/nsw-emergency-fears-due-to-gp-co-payment/story-fni0xqi3-1227084184963?nk=1a57d6e6da6b96f6fb43b8fa4a8086c0 (accessed 4 November 2014).

Mr Archer: We are anticipating another 290,000 presentations in our emergency [departments due to the introduction of the co-payment].

Senator CAMERON: So 290,000 in South Australia, 500,000 in New South Wales. New South Wales have estimated that this is a significant cost burden on hospitals. Is that the same here?

Mr Archer: Absolutely, we have estimated that the cost will be \$80 million.⁵⁷

3.54 Finally on the issue of cost-shifting to the states, the government has indicated that it will allow state emergency departments to introduce a similar co-payment to prevent or reduce the flow of patients.⁵⁸ However the committee understands that many state governments have rejected this option outright.⁵⁹

Cost-shifting to patients

3.55 In addition to the cost-shift to the states, the AMA clearly outlined the very significant costs being shifted by the government from the 2014-15 Budget to individual patients:

Through [the government's proposed] structural changes to Medicare and the PBS, the Government is shifting \$8.4 billion of health care costs onto patients over the next four years.

Assuming that the \$5 rebate cut is offset by the \$7 co-payment, the \$2 difference imposes a further cost on patients of around \$1.4 billion.⁶⁰

3.56 Dr Stephen Duckett, Director of the Health Program at the Grattan Institute explained to the committee the risks associated with burdening patients with additional healthcare costs, which in his view was a return to the healthcare model that pre-dated Medicare:

Certainly, we do not want a system which shifts more costs onto consumers. We do not want a system which introduces financial barriers to access so that people have to find money to see a GP, for example. We do not want systems of that kind. Certainly, I do not think Australians want that...

57 Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 5.

58 The Hon Peter Dutton MP, Minister for Health, *Address to Australian Medical Association National Conference*, 23 May 2014, p. 3.

59 For example NSW–ABC News, *Jillian Skinner says NSW considering inviting GPs to treat patients in hospital to avoid \$7 co-payment*, 17 May 2014, www.abc.net.au/news/2014-05-16/ministers-blast-federal-government-over-missing-80-billion/5458614 (accessed 5 November 2014) and South Australia–ABC News, *Senate health inquiry: GP co-payment will increase SA hospital visits 'by 290,000 people'*, 9 October 2014, www.abc.net.au/news/2014-10-09/co-payment-to-increase-sa-hospital-visits-committee-told/5801886 (accessed 5 November 2014).

60 AMA, *Submission 48*, p. 5. With respect to the \$1.4 billion figure, the AMA noted that 'as the AMA does not have any information about the Government's modelling, this is a simple calculation.'

We had a huge debate in Australia in the sixties and seventies about what sort of health system we wanted. Did we want a system where people who needed to get access to general practitioners or hospitals had to find money to do so? One of my first jobs in the health system was taking people to court to force them to pay their hospital bills... I was working in a public hospital—the Prince Henry Hospital and Prince of Wales Hospital in Sydney. This was before Medicare. I may look like I am only 35, but this was a long time ago!...

This was a debate that was resolved in Australia in the seventies and eighties. It is highly undesirable to have a system where people cannot afford to go to hospital or cannot afford to go to the GP...

There is word—I do not know whether it exists any more—which is 'garnishee', where we actually took almost all of their wages to pay their unpaid public hospital debts.⁶¹

Increase system-wide healthcare costs

3.57 Dr Stephen Duckett has detailed the false economy of the government's \$7 patient co-payment proposal:

In addition to problems of fairness, the \$7 policy is probably bad economics as well. The government's modelling however has been pretty crude: all that's been announced so far is that there will be about 1 per cent fewer visits, that's a drop of about a million visits.

But it's which visits are reduced that is crucial – if they are the wrong ones, health costs could go up instead of down. A GP visit costs government, as a conservative estimate, about \$100, taking into account possible pathology tests or x-rays. 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.

If patients make the wrong judgment call about whether to see a GP just once in every 50 times about whether they should see a GP, and they end up in hospital, then any system savings have vanished. Other costs, such as additional days off work because of worsening conditions or hospital admissions make the economics look even sicker. On top of that, some modelling suggests that waiting times in hospital emergency departments will blow out because of increased demand shifted from GPs.⁶²

61 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, pp 28–29.

62 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *The Drum*, 14 August 2014, <http://grattan.edu.au/news/can-the-coalitions-copayment-policy-be-repaired/>, (accessed 7 November 2014).

3.58 Many other witnesses shared Dr Duckett's concerns, arguing that the impact of the \$7 co-payments will lead to an overall increase in system-wide health costs.⁶³ A compelling example of this was provided by Mr Vahid Saberi, the CEO of Northern NSW Medicare Local:

We did a quick calculation in terms of access to general practice. If a person goes and visits their GP once a week for a whole year, it costs \$1,872 for that whole-year, every-week access. If they go to hospital once at the average rate, which is our average rate of 3½ to four days, that costs \$6,200. So, you can see the difference. Everything we do is to avoid having people go to hospital, because that is where the high costs are, and to provide all the care that we can outside the hospital.⁶⁴

3.59 Drawing on research from the United States, health policy analyst Mr Martyn Goddard confirmed that the proposed \$7 co-payment would increase overall healthcare expenses and not raise any additional Commonwealth revenue:

...it does not take very many people who need to [see a GP] and do not go and who then get sick and then have to go to hospital and have a whole complicated range of things done. As soon as you go into a hospital, the costs are hugely expensive. It does not take very many of those people to massively outweigh the people who drop in [to the GP] for a chat. We have got some data now on that from pretty well designed studies, some in this country but mostly in North America. The study of US medicare with people over 65, which was published in the *New England Journal*, 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...

One of the things that occurred to me is that if the figure is more than about two-and-a-bit times bigger, which I suspect it might be, then because the Commonwealth funds 43 per cent or thereabouts of public hospital costs the cost to the federal budget of hospital costs is probably going to outweigh what it earns or saves through co-payments.⁶⁵

63 For instance Ms Julie Leete, Area Manager, Lismore, Interrelate, *Committee Hansard*, 15 September 2014, p. 34; Mrs Annette Alldrick, Secretary and Delegate, Shoalhaven Branch, NSW Nurses and Midwives' Association, *Committee Hansard*, 16 September 2014, p. 32; Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 2; Mr Darren Carr, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard*, 3 November 2014, p. 9; Dr Judith Watson, Chair, Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 5; and Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch) *Committee Hansard*, 4 November 2014, p. 19.

64 Mr Vahid Saberi, CEO, Northern NSW Medicare Local, *Committee Hansard*, 15 September 2014, p. 23.

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

Health prevention and management

3.60 As a barrier to accessing healthcare, the \$7 co-payment is also a deterrent to people who may be seeking preventative healthcare. This is apparent from the evidence of Mr Stephen Burgess, Innovation, Policy and Research Officer of the aged care service provider Benetas, Victoria, who explained that in deciding whether to seek medical advice, people may consider cost above whether the condition requires treatment or prevention:

The other problem with cost disincentives and barriers to people which are designed, purportedly, to reduce inappropriate use of Medicare funded services by GPs is that the appropriateness or otherwise of a medical consultation is something that can only be made in retrospect, by the doctor, after the consultation... laypeople use a very different rubric for decision making to seek health care, particularly in settings of urgency or emergency cases, and they are not driven by the clinical urgency of the program but rather their emotional reaction to the symptoms that are presenting at the time, whether or not they are in fact life threatening. In fact, there is quite poor correlation between life-threatening symptoms and people recognising how serious they are. Given that laypeople, by necessity, are not experts in health, putting a financial barrier to them accessing people who are is very counterproductive...⁶⁶

3.61 It is clear from evidence presented to the committee that the multiple GP visits, pathology and imaging services required for the management of a chronic disease will soon cause significant cost for users of the healthcare system. Ms Carter, VMAG provided a succinct and personal example of this situation:

My dad needs podiatry every six weeks for a severe hammer toe that impedes him in wearing shoes. But he did not get [his treatment] for a while and developed an ulcer on one of his toes. The GP told him it could result in him losing the toe without proper attention. And that would undermine his mobility, probably put him in a wheelchair faster than the direction he might be heading in...and cost the community far more than a regular podiatry visit every six weeks.

Through community health services, those sorts of services, even for self-funded retirees, can be accessed relatively cheaply. But, for people who are on fixed and low incomes, even the cost of accessing those services through community health services can be significant when you add up all of the co-payments that people are confronted with, particularly as they age or if they have a chronic condition earlier in their lives.⁶⁷

3.62 Mr Hill, Ambulance Employees Australia (Victoria) argued that the consequence of rising costs for those managing a chronic illness would be a lapse in treatment and increased hospital admissions:

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

67 Ms Jane Carter, Spokesperson, VMAG, *Committee Hansard*, 7 October 2014, p. 6.

There are a lot of people in the community who may have, say, a back injury, chronic pain, and they are out of work because of that injury. So they are not on a lot of money and they cannot afford to be seeing their doctor every week. Whether they go to the doctor or not depends on how much money they have in their pocket. This is just a further disincentive to keep in touch with the doctor, to keep on track with whatever medical condition it is they are dealing with. 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.⁶⁸

Administration

3.63 The committee also heard evidence relating to the practical implementation of collecting the co-payment. The evidence of Mr Burgess, Benetas, Melbourne, was particularly concerning as it highlights the complexities and cost implications of administration which will be needed to collect the \$7 co-payment:

Specifically to your question on the realities of making [the administration of the co-payment] work: for every client who has a scheduled GP coming that day—not to mention unscheduled GP visits from locums or for an acute problem—they will need \$7 in cash sitting on the bedside table which then gets handed over to the GP, who must then write a cash receipt for it so it can be recorded in the client record and acquitted under their monthly account under client directed care. Each client is issued a monthly statement which must be accounted for to the cent. Alternatively, the \$7 will need to be taken out of that client's essential pool of care funds and remitted to the GP, whose clinic then has to account for it and send a receipt back for it so it can be accounted for. The practicalities of doing that are very difficult.

The overhead and staff costs are going to vastly exceed the cash amount involved, and it is a perverse incentive because the relationship is actually between the client and the general practitioner. Residential aged care is housing. All of a sudden you have the provider of the housing and the daily support services mediating the relationship with the GP. 'Will I call the GP for client X, who does not appear to be quite as well as usual? Their cognitive impairment seems a bit worse. Some of their behaviours are a little bit more extreme than normal, but they do not appear actually unwell. If I make the call then the client will be bearing the financial cost. If I do not make the call then the client bears the health risk of not receiving the medical care that they might need'—not to mention the administrative burden that sits there. It may well be that there are tensions between the provider of the residential aged-care facility and, for example, family members who might get the monthly statements and wonder where all this

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

money has gone. 'Why did you ring the doctor for my mother when the doctor turned up and said there was nothing wrong?'⁶⁹

3.64 The committee heard about administrative and cost burden the \$7 co-payment will have on the thousands of GP practices across Australia. Dr Carlson who operates a general practice on the South Coast of NSW explained of the unexpected impacts of the \$7 co-payments to small private GP practices:

...there is not a hope in Hades of developing by July next year the software that can cope with it [the GP 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.⁷⁰

3.65 The committee also heard evidence from the South Australian Department of Health and Ageing about the practical administrative burden of collecting a \$7 co-payment. Although the response was given in the context of a state-based emergency department co-payment, which the Federal Government has promoted but the South Australian Government has firmly rejected, and although the South Australian official was cautious in his response, it shows that the significant cost burden that could potentially flow from the \$7 co-payments:

...we have not looked specifically at what the cost of administering it would be, because at this point in time we do not know how we would administer it or what we would do. The comments [that the cost of administering a \$7 co-payment would be significantly more than \$7] were based on the normal cost of collection for our current debtors, if you like—what that normally costs to process. It is significant. I think it is of the order of \$30 per transaction, from memory. That is purely through our shared services arrangements.⁷¹

3.66 The administrative burden resulting from the \$7 co-payment would also be felt by organisations providing Indigenous health services. The Aboriginal Health Council of South Australia told the committee that Aboriginal Australians, being amongst the lowest income section of the Australian population, would struggle to pay the \$7 co-payment. In order to incentivise their community to use health services and seek early treatment, groups would have to take the co-payment cost on themselves. Ms Amanda Mitchell, Health Development Coordinator, Aboriginal Health Council of South Australia, told the committee that the issue had been raised at a roundtable with Assistant Minister for Health, Senator the Hon Fiona Nash:

69 Mr Stephen Burgess, Innovation, Policy and Research Officer, Benetas, *Committee Hansard*, 7 October 2014, p. 10.

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

71 Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 6.

This issue was brought up on that teleconference with Minister Nash and some of the CEOs of the others state affiliates mentioned some of these flow-on effects to on-the-ground services. A question was asked, 'Can't the Aboriginal people who work pay the \$7 and the unemployed not pay?' That would mean the services would have to do means testing, they would have to have cash on premises. Just because an Aboriginal person works does not mean they can pay this all the time. A lot of the time we are supporting other family members, extended family. There are costs that everyone has for themselves. There was quite a bit of concern about this question when it was raised. One of the CEOs said if we do not charge the \$7 it could be \$350,000 per year that we would have to find out of our own money to make sure that Aboriginal people come to our service. There are extra costs that are involved in seeing patients.⁷²

Links to the Medical Research Future Fund

3.67 In the 2014-15 Budget the government announced plans to establish a \$20 billion Medical Research Future Fund (MRFF).⁷³ The government has directly linked the MRFF to the \$7 co-payments, with \$5 of every \$7 going to the MRFF.

3.68 Witnesses to the inquiry were highly critical of the government's decision to link these two proposals. Witnesses generally expressed strong support for increased public investment in medical research, but not at the expense of burdening the most vulnerable in our community with a \$7 co-payment. Professor Mike Daube, Curtin University, and former head of the Western Australian health department expressed the sentiment of many witnesses:

...of course I strongly support medical research but I cannot see any reason to tie medical research into the co-payment process. We should be funding more medical research from other sources and there are ready-made sources. Examples would be the \$14 billion or so that we get from alcohol and tobacco tax...⁷⁴

3.69 A similar concern was expressed by the VMAG spokesperson:

I certainly agree that there are very mixed messages about precisely what the government's motivation is [in implementing the co-payments]. Ostensibly, it was to fund this medical research fund—on the backs of the people who need the health system most. That seems extremely bizarre, particularly given that they will not benefit from this medical research fund,

72 Ms Amanda Mitchell, Health Development Coordinator, Aboriginal Health Council of South Australia, *Committee Hansard*, 9 October 2014, p. 47.

73 Budget Paper No.2: Budget Measures – Health. www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm.

74 Professor Mike Daube, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; and Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, 10 October 2014, p. 21.

given that it is estimated that it will take quite a while to actually build up a significant corpus in it.⁷⁵

Committee comment

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

3.71 Grave concerns were expressed about the government's plan which was described as fundamentally undermining the principle of universal primary healthcare. In the committee's view, the government's \$7 co-payment is a significant regressive step.

3.72 Perhaps the strongest objection to the government's \$7 co-payment is the disproportionate impact it will have on the most vulnerable sections of the Australian community. The list of vulnerable groups ranges from the elderly to the poor, from Indigenous Australians to those in rural and remote areas, from those with chronic conditions to those with mental illnesses. These Australians will bear the brunt of the financial costs associated with the government's \$7 co-payment but also will suffer worse health outcomes as a direct result.

3.73 Several significant and perverse economic outcomes were also raised as a highly problematic aspect of the government's \$7 co-payment. Firstly, the tax was described by economic health experts as ineffective in the area of primary care. It cannot possibly target the GP visits, pathology and imaging services and prescription medicines that the government has described as "unnecessary" without also increasing preventable illnesses through the deferral of necessary healthcare. Secondly, it poses a substantial cost-shift from the Commonwealth Budget to state emergency departments and individual patients. In doing so it would lead to even greater pressures on already overstretched emergency departments as well as higher system-wide healthcare costs due to a greater reliance on more expensive hospital treatments.

3.74 For patients with complex chronic health conditions such as diabetes and obesity, the government's \$7 co-payment will result in people delaying much needed primary care treatments. This will ultimately lead to patients needing attention for acute conditions, greater cost imposts on both the patient and the health system, and worse health outcomes for the patient and the system.

3.75 Finally, the \$7 co-payment will create additional cost and administrative burdens and red tape for healthcare providers across Australia. This appears to be inconsistent with the government's mantra about reducing red tape.

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

75 Ms Jane Carter, Spokesperson, Victorian Medicare Action Group, *Committee Hansard*, 7 October 2014, p. 3.

3.77 Accordingly, the committee makes the following recommendation.

Recommendation 1

3.78 The committee recommends that the government should immediately abandon its plan to implement the \$7 co-payments.

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

Cuts to hospital funding

3.80 Many organisations and individuals have expressed frustration and disappointment at the government's announcement in the 2014-15 Budget that \$50 billion would be cut from the public hospital system over ten years. Similarly, all state premiers and territory chief ministers reacted negatively to this announcement.⁷⁶

3.81 Witnesses and submitters to this inquiry, including the South Australian Premier and the South Australian Department of Health and Ageing, the Royal College of Physicians and the Australasian College of Emergency Medicine, all relayed their strong opposition to the cuts. Many submitters and witnesses argued that the cuts would place an already overstretched public hospital system under unnecessary additional pressure.

3.82 The Premier of South Australia, the Hon Jay Weatherill detailed the severity of cuts in funding and services to his state. While acknowledging a total reduction of \$80 billion in health and education funding, the Premier submitted:

I want to direct my remarks today to essentially the federal budget and the changes in the budget which affect all states and territories, [which is] in the order of \$80 billion in cuts to our state health and education systems over the next 10 years. South Australia's share of that is \$5.5 billion over the next 10 years. Most of that is in health... It is \$4.6 billion over the next 10 years in health. In the next four years alone, the health cuts amount to \$655 million.⁷⁷

3.83 Premier Weatherill explained that the federal government had reneged upon the previously signed health expenditure agreements between the Commonwealth and South Australian governments. These agreements, equating to funding cuts of \$655 million over four years included the:

- National Health Reform Agreement;

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

77 Hon Jay Weatherill MHA, Premier, South Australian Government, Committee Hansard, 28 August 2014, p. 1.

- National Partnership Agreement on Improving Public Hospital Services;
- National Partnership Agreement on Financial Assistance for Long Stay Older Patients;
- Health National Partnership reward payments;
- National Partnership Agreement on Preventive Health; and
- National Partnership Agreement on Indigenous Early Childhood Development.⁷⁸

3.84 Finally, Premier Weatherill described the frustration felt by premiers and chief ministers, who in Council of Australian Government (COAG) meetings with the Prime Minister in early May, less than two weeks before the budget, were not told of the \$80 billion in cuts to state and territory governments for health and education services.⁷⁹

3.85 In related evidence from the South Australian Department of Health and Ageing, the committee learned of the additional pressure that the announced cuts will place on public hospitals in South Australia. Mr Archer, Deputy Chief Executive Officer of the department explained that of the total \$5.248 billion in the South Australian health budget, \$1.5 billion is sourced from the federal government. As the federal government is a significant financial partner in the health of Australians, it was particularly difficult for the department to plan over the short term, due to the severity of the cuts:

The federal health budget reductions will mean that South Australia will receive approximately \$444 million less over the next four years for public hospital services when compared to what was published in the 2013-14 Mid-Year Economic and Fiscal Outlook. This grows to a loss of \$4.6 billion over the next 10 years. These reductions relate to the cessation of funding guarantees under the National Health Reform Agreement, not increasing contributions to 50 per cent of the efficient public health service expenditure and new indexation arrangements from 2017-18 to a composite CPI and population growth.⁸⁰

3.86 The AMA Victoria argued that the cuts would be detrimental to the Victorian health system. The AMA Victoria's analysis revealed that cancellation of the health reform agreements would result in cuts of about \$676 million over the next three years.⁸¹ The AMA Victoria's President, Dr Bartone told the committee of likely

78 Hon Jay Weatherill MHA, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 1.

79 Hon Jay Weatherill MHA, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 1.

80 Mr Stephen Archer, Deputy Chief Executive, Department of Health and Ageing, South Australia, *Committee Hansard*, p. 1.

81 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 38.

outcome to the Victorian public hospital system if funding uncertainty continued in the short and medium term:

Simply there is a lot of ambiguity and uncertainty going forward. The decisions around health care need to be planned well in advance. We cannot have a system of changing or moving the chess pieces. Hospitals need to forward plan their budgets more than the current financial year. Putting the horse before the cart is only going to result in programs getting lost, elective surgery waiting lists falling apart and operating theatres being brought to a halt because suddenly they are running out of money.⁸²

3.87 The AMA Victoria also gave evidence that, the federal government did not consult stakeholders or service providers prior to the removal of \$50 billion from the health system, stating that there was 'zero' consultation prior to the announcement in May. Dr Bartone expressed frustration at having being 'stonewalled' by the government following the release of the National Commission of Audit report:

Dr Bartone: There were a lot of murmurings and gestures. There was a lot of corridor discussion of what was going to happen. I heard this and I heard that, but there was no formal meeting to say what was being proposed. Our previous federal president did try to meet on many occasions to get a better understanding of what was going to be released but was stonewalled in terms of clarity about where the government was heading. We did put on record, as soon as the Commission of Audit came out with its findings, that we were opposed to even its more adventurous, shall we say, targets. We clearly put that out there at the time. We were expecting some bad news but not what we got.

CHAIR: They are important numbers—zero for consultation and \$50 billion for cuts over 10 years. It is a dangerous mix—is it not?

Dr Bartone: Absolutely.⁸³

3.88 The Australasian College of Emergency Medicine argued that continued cuts to health funding and services could result in an exodus of medical professionals overseas due to the compounding effect of additional pressures public hospitals are experiencing:

I am saying with the budget cuts and the increasing requirement to do more with less, the impost on people's working conditions, the requirement to actually do things that are outside your ability to do—which is what is happening in the UK. I am looking at what has happened overseas and hoping that we do not go down that pathway.⁸⁴

82 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 41.

83 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 44.

84 Ms Alana Killen, Chief Executive Officer, Australasian College of Emergency Medicine, *Committee Hansard*, 8 October 2014, p. 20.

3.89 The Grattan Institute submitted that the government's decision to cease activity based funding and return to block funding would create incentives for the states to cost-shift back to the Commonwealth:

I think the shift away from the shared activity based funding was a retrograde step. It had a number of attributes which you have mentioned, one of which is transparency. Importantly, from my perspective was the alignment of incentives. If the Commonwealth government were at risk of spending additional money because of hospital activity increases then it was in the Commonwealth's interest to actually improve primary care services to reduce demand on hospitals...

[Shared activity based funding] gave the Commonwealth skin in the game to try to reduce public hospital expenditure. Interestingly, the budget has increase the incentives on the states to cost shift to the Commonwealth. It is the most amazingly perverse policy you could possibly imagine in that regard. It now says that there is no reward to the states for doing additional activity, so they can say, 'We will label this additional activity as Commonwealth activity,' and cost shift it.⁸⁵

3.90 The AMA was also critical of the moves by the federal government to move away from activity based funding, arguing that block funding adjusted for population growth and CPI would result in more inefficiencies in the public hospital system:

Activity based funding provides transparency in terms of the activities that are funded. It provides a mechanism to deal with inefficiencies in the public hospital system by enabling comparison of costs and the activities and services produced. [Activity Based Funding] classification of activities, together with the transparent application of standard costs, enables better assessment of performance and informed consideration of issues like unwarranted clinical variation.⁸⁶

Committee comment

3.91 The committee is greatly troubled by the evidence relating to the government's cuts of \$50 billion to hospitals across Australia which demonstrates the detrimental effects of these cuts on public hospital systems already under pressure.

3.92 The committee is concerned by the government's decision to renege on hospital funding agreements, the abandonment of activity based funding and the return to block funding for public hospitals. The committee strongly supports activity based funding as it incentivises system-wide efficiency improvements and minimises the cost-shifting associated with block funding.

85 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, p. 33.

86 Australian Medical Association, *Submission 48*, p. 3.

Recommendation 2

3.93 The committee notes the evidence of the negative implications of the government's:

- **changed hospital funding indexation arrangements that will see public hospitals funded on the basis of population growth and CPI;**
- **cuts to the National Health Reform Agreements and associated National Partnership Agreements; and**
- **lack of commitment to Activity Based Funding.**

3.94 The evidence points to a significant loss of health services in Australia's public hospitals if these changes proceed.

3.95 On the basis of the evidence to the committee, the government should restate its commitment to Activity Based Funding and associated reforms.

Abolition of the Australian National Preventative Health Agency

3.96 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.⁸⁷

3.97 The Victorian Health Promotion Foundation observed that despite the cost effectiveness of health prevention, Australia invests just two per cent of all health expenditure in health promotion and disease prevention programs—low by international standards.⁸⁸

3.98 The committee heard persuasive evidence from numerous submitters that the government's decision to abolish of the Australian National Preventative Health Agency (ANPHA) was a critical mistake that would result in significantly higher health expenditure over the long term. Many witnesses and submitters argued that the abolition of the ANPHA was a regressive step that ignored significant research that demonstrates the enormous financial, social and health benefits of preventative health programs.

3.99 For instance the AMA Victoria argued that as chronic disease is the driving force in healthcare funding in Australia, further cuts to health prevention programs would have a profoundly negative effect on both health and financial outcomes for Australians:

In Australia, chronic disease is the dominant driver of health care spending. It accounts for half of all hospital costs. Further cuts to prevention and

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

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

health promotion will only compound the problem. The best way to treat chronic diseases is to prevent people developing them in the first place.⁸⁹

3.100 VMAG was also strongly critical of the abolition of the ANPHA. It argued that it would result in Australia's health system mirroring the two-tier system in the United States, and consequentially see less use of preventative health measures. VMAG argued:

So we support a strong shift in emphasis to evidence-informed prevention and health promotion strategies. Again, things like the abolition of the Australian National Preventive Health Agency, we think, send the wrong message.⁹⁰

3.101 The Australian Nursing and Midwifery Federation South Australia (ANMFSA) argued that the Commonwealth, through the abolition of the ANPHA and the National Partnership Agreement on Preventative Health was effectively walking away from its role in primary and preventative health care:

Under the reform agreement, the Commonwealth was to assume a greater role for the funding of primary health services. That is a wider role than the historic federal role in the funding of primary medical services. It took the Commonwealth into a greater responsibility for funding of community based health care, particularly into the areas of multidisciplinary healthcare delivery for disease prevention and for health promotion.⁹¹

3.102 The ANMFSA argued that the cuts by the Commonwealth government to preventative health programs are both short-sighted and counterintuitive. It submitted that any short-term "saving" would result in a significant increase in demand in the long-term.⁹²

3.103 The AMA also shared the view that the cancellation of the National Partnership Agreement on Preventative Health would result in significantly higher costs to the health system.⁹³

3.104 The legislation to abolish ANPHA was defeated in the Senate on 25 November 2014.⁹⁴ Despite this, by 2 July 2014 the government had completed the transfer of staff, files and functions from ANPHA to the Department of Health.⁹⁵ The

89 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, 7 October 2014, p. 37.

90 Ms Jane Carter, Spokesperson, VMAG, *Committee Hansard*, 7 October 2014, p. 2.

91 Adjunct Associate Professor Elizabeth Dabars AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, pp 29–30.

92 Adjunct Associate Professor Elizabeth Dabars AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, p 30.

93 AMA, *Submission 48*, p. 3.

94 *Journals of the Senate*, 25 November 2014, p. 1848.

95 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.

2014-15 Budget removed ANPHA's future funding, claiming this as a "savings" measure.⁹⁶

Committee comment

3.105 The committee is not satisfied that the abolition of ANPHA will result in any significant budgetary savings. The government has proposed that ANPHA's functions will be integrated into the Department of Health so the cost of running ANPHA's programs will still be a Commonwealth responsibility.

3.106 The committee is however persuaded by the evidence that the work of ANPHA is crucial to reducing illness in the medium and long term, and would provide significantly greater health and financial outcomes for both patients and governments. The committee notes the extensive evidence that demonstrates the positive outcomes of investments in preventative health.

3.107 The committee considers the defeat of the bill to abolish ANPHA sends a clear signal to the government of the lack of support for this measure. The committee urges the government to reconsider its proposal to abolish ANPHA.

Recommendation 3

3.108 The committee recommends that, based on the evidence before it, and the demonstrated benefits arising from the work of the Australian National Preventive Health Agency (ANPHA) and the National Partnership Agreement on Preventive Health, the government should drop its plans to abolish ANPHA and reinstate the National Partnership Agreement on Preventative Health.

96 'Smaller Government – Australian National Preventative Health Agency – abolish' Budget Measures 2014-15 – Part 2, p. 145.

Chapter 4

Medicare Locals—history and implementation

Establishment

4.1 The establishment of 61 Medicare Locals across Australia was one of the key reforms under the National Health Reform Agreement (NHRA). The NHRA formed the basis for the then Labor Government's implementation of the recommendations made by the National Health and Hospitals Reform Commission (NHHRC).

4.2 Formed in 2008, the NHHRC was created 'to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term'.¹ The NHHRC's June 2009 report provided the foundation for the NHRA and health funding announced by the Labor Government in 2011.

4.3 Medicare Locals were a key element of a strengthened primary care system which focused on integration of services and joint Commonwealth and State government planning for service delivery and access.²

4.4 Under the NHRA, the Commonwealth Government had responsibility for the establishment of the Medicare Locals.³ The Medicare Locals were funded with \$1.8 billion over five years from 2011-12 to 2015-16.⁴

4.5 A lengthy consultation process led by the Department of Health and Ageing was conducted prior to the establishment of the Medicare Locals. Groups who participated included:

- Australian General Practice Network;
- state and territory health departments;
- individual Divisions of General Practice;
- medical bodies (including the Royal Australasian College of Physicians and the Royal Australian College of General Practitioners);

1 National Health and Hospitals Reform Commission, Terms of Reference, <http://nhhrc.org.au/terms-of-reference/>.

2 *A National Health and Hospitals Network for Australia's Future*, Government publication, 2010, p. 5.

3 Council of Australian Governments, *National Health Reform Agreement*, 2011, p. 6. <http://webarchive.nla.gov.au/gov/20140801015609/http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-agreement>.

4 *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, Professor John Horvath AO, 4 March 2014, p. 2.

- the Australian Medical Association;
- allied health professional groups such as the Pharmacy Guild;
- intellectual disability groups;
- Aboriginal and Torres Strait Islander health organisations and other stakeholders in the sector.⁵

4.6 Following a competitive application process, 61 Medicare Locals were established in three tranches: 19 Medicare Locals were established from 1 July 2011; 15 Medicare Locals commenced from 1 January 2012; and the remainder from 1 July 2012.⁶

4.7 Also operational from 1 July 2011 was the after hours GP helpline, which by August 2011 had received over 20 000 calls. Medicare Locals were funded to also improve access to after hours care or more specifically to:

...to review the after hours primary health care needs of their region and address urgent gaps in care, ensuring that communities across their region have suitable after hours services in place.⁷

4.8 Medicare Locals are non-profit companies which are principally funded by the federal government and which operate independently. Each Medicare Local has a Deed for Funding through which government funding is allocated and which specifies program schedules and reporting requirements.⁸ Medicare Locals are also able to source additional funding through state government grants or fundraising activities.

Purpose

4.9 Medicare Locals were part of a renewed focus on primary care, 'to work with the full spectrum of General Practice, allied health and community health care providers and improve access to care and drive integration between services'.⁹

4.10 The task of Medicare Locals, including their relationship to GPs, was explained further as:

While GPs remain at the centre of primary health care and responsible for individual patient care, Medicare Locals will be responsible for developing

5 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, pp 17–18, <http://webarchive.nla.gov.au/gov/20140801015101/http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhr-progress-delivery>, (accessed 7 November 2014).

6 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, pp 17–18.

7 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, p. 18.

8 *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, Professor John Horvath AO, 4 March 2014, pp 2–3.

9 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, p. 16.

strategies to meet the overall primary health care needs of their communities. They will ensure the primary health care services needed by their communities work effectively for patients, through developing collaborative arrangements between health service providers in their area. They will also plan and support local after hours face-to-face GP services.

Medicare Locals will work closely with Local Hospital Networks and the new front end for aged care to deliver better integration and smoother transitions for patients across the entire health care system...

A stronger primary health care system will be supported by joint planning with states and territories and Medicare Locals to improve the delivery of primary health care services in the local community.¹⁰

4.11 Funding was also allocated for the Australian Medicare Local Alliance, a peak body for the 61 Medicare Locals. The Alliance's role was to 'lead, coordinate and support' the Medicare Locals.¹¹

Activities of Medicare Locals

4.12 Medicare Locals were designed to take an active role in identifying gaps in primary health care and improving service delivery. For example:

Medicare Locals will be responsible for improving primary health care service delivery at the local level, to reduce service gaps and improve access to high quality integrated care centred around patients' needs. For instance, a Medicare Local, in consultation with local GPs, might identify that there are a large number of diabetics 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.

Subject to final agreement with the states, Medicare Locals may play an increasing role in delivering services currently funded by states but set to transfer to the Commonwealth through the Government's reforms. The Commonwealth and the states have already agreed to roll any primary care coordination functions into Medicare Locals to reduce duplication. States have agreed to align related programs with Medicare Locals as much as possible.¹²

4.13 The submission from the Australian Medicare Local Alliance sets out the strategic objectives of the Medicare Locals:

- improving the patient journey through developing integrated and coordinated services;
- providing support to clinicians and service providers to improve patient care;

10 *National Health Reform Process and Delivery Publication*, Australian Government, September 2011, p. 16.

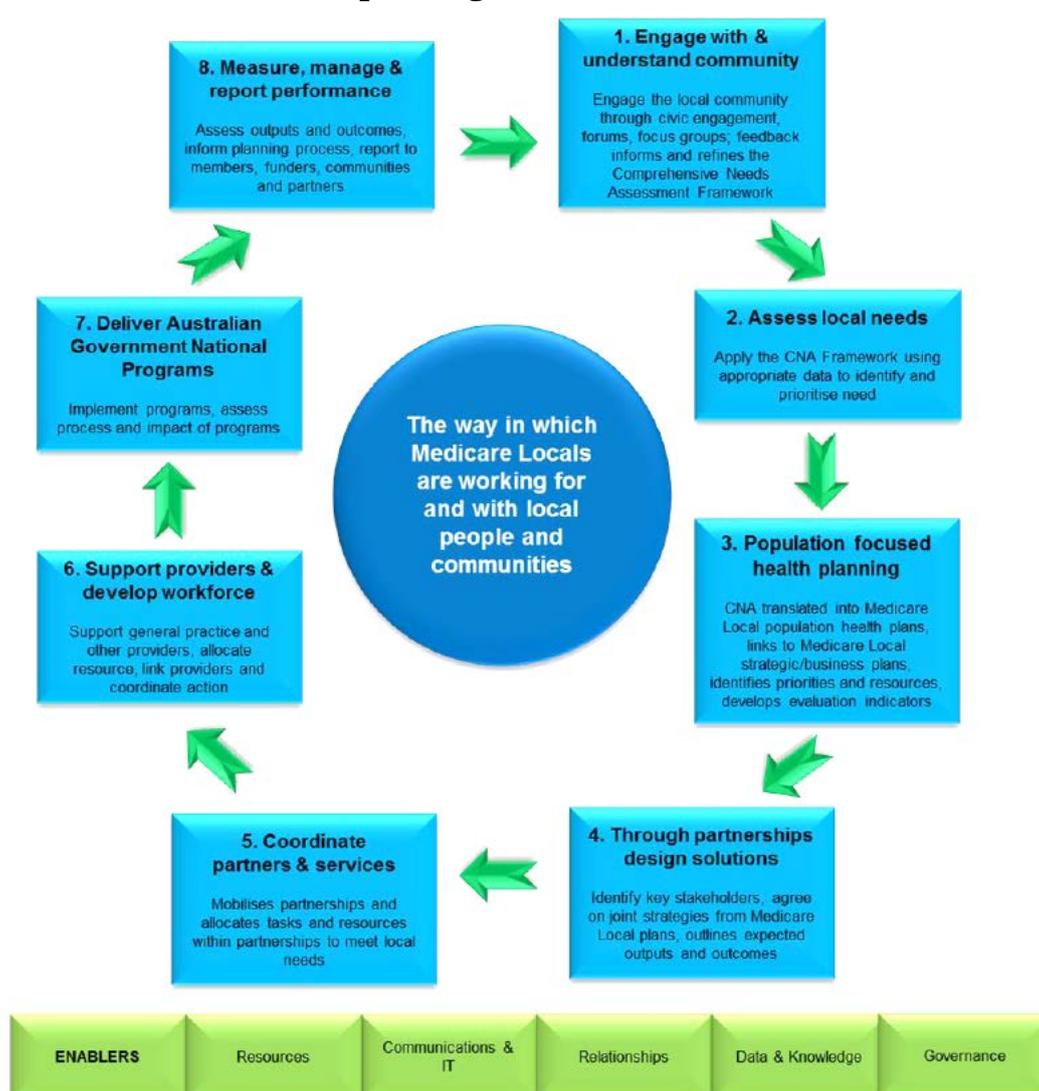
11 Australian Medicare Local Alliance (In Liquidation), *Submission 82*, p. 1.

12 'A National Health and Hospitals Network for Australia's Future' Government publication, 2010, p. 40.

- identifying the health needs of their local areas and development of locally focused and responsive services;
- facilitating the implementation of primary health care initiatives and programs; and
- being efficient and accountable with strong governance and effective management.¹³

4.14 The operating model of the Medicare Locals to achieve these objectives is also set out by the Alliance, in the figure below.

Figure 1—Medicare Locals operating model¹⁴



¹³ Australian Medicare Local Alliance, *Submission 82*, p. 6.

¹⁴ Australian Medicare Local Alliance, *Submission 82*, p. 6.

Primary Health Networks

Policy change

4.15 Medicare Locals were mentioned only briefly in the August 2013 Coalition health policy, *The Coalition's Policy to Support Australia's Health System*. The policy notes that 'We [the Coalition] will also review the Medicare Locals structure to ensure that funding is being spent as effectively as possible to support frontline services rather than administration.'¹⁵

4.16 During the leadership debate in 2013, in answer to a question by a member of the audience, the then Opposition Leader, the Hon Tony Abbott MP made a promise that no Medicare Locals would be closed should the Coalition form government.¹⁶

4.17 However, on 16 December 2013, the new Minister for Health, the Hon Peter Dutton MP announced a review into the Medicare Locals to be conducted by Professor John Horvath AO.¹⁷ A media release on 16 December 2013 quoted the Minister for Health as saying that the purpose of the review was 'reducing waste and spending on administration and bureaucracy, so that greater investment can be made in services that directly benefit patients and support health professionals who deliver those services to patients.'¹⁸

4.18 The review recommended that the Medicare Locals be closed and a new network of 'Primary Health Organisations' be established.¹⁹

4.19 While the review was completed in March 2014, it was not until the 2014-15 Budget that the government announced all Medicare Locals would cease operation on 30 June 2014 and a new network of Primary Health Networks (PHNs) would be established.

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- 15 *The Coalition's Policy to Support Australia's Health System*, Liberal and National Parties, August 2013, <http://paweb-static.s3.amazonaws.com/13-08-22%20The%20Coalition%E2%80%99s%20Policy%20to%20Support%20Australia%E2%80%99s%20Health%20System.pdf>, p. 3.
- 16 The Hon Tony Abbott MP (Opposition Leader), *People's Forum 2*, transcript, ABC News 24, 28 August 2013.
- 17 Health Minister the Hon Peter Dutton MP, Media release, *Medicare Locals review: Australia's former Chief Medical Officer Prof John Horvath AO will oversee the Australian Government's review of Medicare Locals*, 16 December 2013, www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2013-dutton025.htm.
- 18 Health Minister the Hon Peter Dutton MP, Media release, *Medicare Locals review: Australia's former Chief Medical Officer Prof John Horvath AO will oversee the Australian Government's review of Medicare Locals*, 16 December 2013.
- 19 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, Executive Summary, p. v.

The Review of Medicare Locals

4.20 The Minister for Health announced the terms of reference for the Review of Medicare Locals (the Review) on 16 December 2013, and at the same time invited stakeholder comment:

Stakeholders have been invited to comment on various aspects of Medicare Locals' functions including:

- The role of MLs [Medicare Locals] and their performance against stated objectives
- The performance of MLs in administering existing programmes, including after-hours GP services
- Recognising general practice as the cornerstone of primary care in the ML functions and governance structures
- Ensuring Commonwealth funding supports clinical services, rather than administration
- Processes for ensuring that existing clinical services are not disrupted or discouraged by ML programs
- Interaction between MLs and Local Hospital Networks and other health services, including boundaries
- Tendering and contracting arrangements
- Other related matters²⁰

4.21 Professor Horvath, the former Chief Medical Officer, was appointed to conduct the Review. In his work he was assisted by the Department of Health, and he drew upon work conducted by two consultants:

A review on the functioning of Medicare Locals: Conducted by Ernst & Young (EY) this review provided analysis and opinion on current Medicare Locals operations and potential future governance options.

An independent financial audit of Medicare Locals: Undertaken by Deloitte Touche Tohmatsu (Deloitte), the audit provided an assessment of Medicare Locals compliance to their Deed and financial performance.²¹

4.22 In addition to the consultant reports, Professor Horvath stated that he also '...personally held interviews with a number of key stakeholders and opinion leaders'.²²

20 www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2013-dutton025.htm.

21 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport* 4 March 2014, p. 3.

22 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 3.

4.23 Professor Horvath wrote: 'The Department of Health invited selected stakeholders to make submissions to inform the Review. Over 270 submissions were received. Over half of these submissions were unsolicited, highlighting the significant interest in the Review.'²³ The submissions were not published either on the Department of Health's website or as supporting documentation with the Review.

No information on Review process

4.24 The Review findings were provided to the government on 4 March 2014.

4.25 The committee has been able to obtain very little information about the process and methodology used to conduct the Review. What information the committee has been able to gather has come from public hearings.

4.26 The committee heard that those Medicare Locals who were asked for input to the Review were restricted in what they could provide. Ms Kathryn Stonestreet, CEO of the Southern NSW Medicare Local told the committee:

We were asked to give an opinion and I think we had to keep it to three pages—it was short—in terms of what Medicare Locals are, our achievements and the potential issues. All Medicare Locals could participate plus other organisations like the AMA and such.²⁴

4.27 The Northern Adelaide Medicare Local published its three page input to the Horvath Review on its website.²⁵ The small font size, dot points, pages crammed with information and the need for 15 pages of attachments clearly indicate that the three page limit imposed by the Horvath Review was inadequate to explain the achievements of a Medicare Local.²⁶

4.28 It seems that other Medicare Locals did not have the opportunity to provide input to the Review. Mrs Brenda Ryan, CEO, Goldfields-Midwest Medicare Local (GMML) in Western Australia told the committee that the GMML was not consulted.²⁷ Similarly Mr Paul Hersey, CEO, Perth South Coast Medicare Local (PSCML), Western Australia, was not approached by the Review.²⁸

4.29 However Mr Hersey contributed to the Deloitte audit and he believed that the PSCML was one of six Medicare Locals, out of a possible 61 Medicare Locals, involved in the audit. Mr Hersey noted that there had been no major issues identified

23 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 3.

24 Ms Kathryn Stonestreet, CEO Southern NSW Medicare Local, *Committee Hansard*, 16 September 2014, p. 5.

25 Northern Adelaide Medicare Local, www.naml.com.au/about-us.

26 Northern Adelaide Medicare Local, www.naml.com.au/about-us.

27 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 12.

28 Mr Paul Hersey, CEO South Coastal Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 12.

in the PSCML audit, however he was concerned about the timing of the audit and believed that the audit results should be viewed in context:

My main concern with the Deloitte process was that it looked at a point in time. It was always firmly in the rear-view mirror and by the time the audit took place it looked at the 2012-13 financial year, which was when Medicare Locals had just been established. With any issues that Deloitte raised with me, a typical conversation would be, 'That may have been the case at that point in time, whereas this year we are doing things differently.' Deloitte acknowledged that throughout.²⁹

4.30 The work of the audit was described by Mr Mark Booth, Department of Health, as 'essentially a basic audit' with six Medicare Locals involved in a more intensive 'side visit'.³⁰

4.31 A number of organisations have advised the committee that they made submissions to the Review of Medicare Locals, including the Consumer Health Forum of Australia (CHF)³¹ and the Australian Medical Association (AMA).³²

Committee comment

4.32 With limited information available publicly, and no detailed discussion of methodology in the Review report, it is difficult to understand the Review's recommendations. Similarly, without the transparency that would have been achieved by the publication of the consultancy reports and the 270 submissions, the Review's assertions that the Medicare Locals are "flawed" cannot be tested.

Government response

4.33 Prior to the Budget being handed down, communities believed that despite the findings of the Review no Medicare Locals would be closed.³³ These views were based on a firm public statement by the now Prime Minister that no Medicare Locals would be closed should the Coalition form government.³⁴ For example, the Northern Adelaide Medicare Local Board Chair, Dr Nick Vlachoulis published a media release on 23 April 2014 to reassure staff and consumers that the Medicare Locals would continue:

29 Mr Paul Hersey, CEO South Coastal Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 12.

30 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Senate Community Affairs Legislation Committee, *Supplementary Estimates*, 22 October 2014, p. 34.

31 This submission was provided to the committee upon request.

32 This submission is available on the AMA website: <https://ama.com.au/submission-australian-government-review-medicare-locals>

33 Northern Adelaide Medicare Local Media Release, *Media speculation around Medicare Locals*, 23 April 2014, www.naml.com.au/media-centre/latest-news.

34 The Hon Tony Abbott MP (Opposition Leader), *People's Forum 2*, transcript, ABC News 24, 28 August 2013.

Recent rumours that Medicare Locals will be axed as part of the Federal Budget is purely speculation, says Northern Adelaide Medicare Local (NAML) Board Chair, Dr Nick Vlachoulis.

"NAML has a contract with the Commonwealth for Medical Local funding through to June 2016 and Tony Abbott said prior to the election last year that Medicare Locals would not be closed" Dr Vlachoulis said. Dr Vlachoulis highlighted that the majority of staff employed at NAML are frontline health workers who provide services and programs directly to the community.³⁵

4.34 The 2014-15 Budget announced that all 61 Medicare Locals would be closed and a new smaller system of PHNs would be established.³⁶

4.35 The Department of Health has stated that the cost of establishing the Primary Health Networks will be drawn entirely from departmental resources. The government has not clarified what will happen to any remaining funding from the \$1.8 billion allocated over five years for the support of the current 61 Medicare Locals. The Budget Papers explain:

The Government will refocus primary care funding by replacing Medicare Locals with Primary Health Networks from 1 July 2015. The Primary Health Networks will establish Clinical Councils, with a significant GP presence, and local Consumer Advisory Committees that are aligned to Local Hospital Networks, to ensure primary health care and acute care sectors work together to improve patient care.³⁷

Committee comment

4.36 The committee believes that without more information about the processes and methodology used by the Review, and without the publication of the consultancy reports and the 270 submissions, the Review's findings cannot be subjected to proper scrutiny.

4.37 The evidence the committee has heard, and the few submissions the committee has seen that were made to the Review, raise a large number of questions. Further, the committee is concerned by the disparity of the evidence it has heard of the achievements of Medicare Locals and the highly critical and negative findings the Review made about the work of the Medicare Locals.

35 Northern Adelaide Medicare Local Media Release, *Media speculation around Medicare Locals*, 23 April 2014, www.naml.com.au/media-centre/latest-news.

36 The Horvath Review refers to Primary Health Organisations, but the Government has opted for the alternative name 'Primary Health Networks'.

37 2014-15 Budget, Budget Paper No. 2: Budget Measures 'Establishment of Primary Health Networks', p. 129.

The costs of implementing Primary Health Networks

Introduction

4.38 This section focuses on the impact of the government's decision to close Medicare Locals, the loss of frontline services already reported to the committee and the confusion surrounding the tender process to establish the PHNs.

Closure of Medicare Locals

4.39 In the 2014-15 Budget the government announced:

The Government will refocus primary care funding by replacing Medicare Locals with Primary Health Networks from 1 July 2015. The Primary Health Networks will establish Clinical Councils, with a significant GP presence, and local Consumer Advisory Committees that are aligned to Local Hospital Networks, to ensure primary health care and acute care sectors work together to improve patient care.

The cost of this measure will be met from within the existing resources of the Department of Health.³⁸

4.40 The effect of this decision is that funding will cease for Medicare Locals on 30 June 2015. By that time, the government's intention is that PHNs will have been selected through a tender process and be ready to operate from 1 July 2015.

4.41 The committee has heard much evidence regarding the wind up of the Medicare Locals and the tender process for the PHNs. Issues which emerged consistently in evidence included:

- concerns over the permanent loss of important frontline 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 up to \$112 million cost of closing Medicare Locals; and
- confusion about the role and timeline for the tender for PHNs and the late provision of the boundary information.

4.42 Whether Medicare Locals participate in the tender for PHNs, or continue without government funding, or close entirely, it will be important that vital services are not lost, that the good work of Medicare Locals in population health, closing gaps in services and better integration of primary care is not lost in the process.

Loss of services provided by Medicare Locals

4.43 The closure of Medicare Locals and the establishment of a smaller number of PHNs does not in any way guarantee the retention of the diverse range of services

38 Budget Paper No. 2: Budget Measures – Health. www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm.

provided by the Medicare Locals. Valuable work that is likely to be lost in the transition includes:

- service delivery programs, particularly preventative health and mental health programs;
- the creation of a health care support model which includes consumers, GPs and allied health professionals working together;
- networks and relationships with NGOs, state governments and service providers; and
- community goodwill and support.

This is by no means a complete list.

4.44 Mr Phil Edmondson, CEO, Tasmania Medicare Local, told the committee that it had taken two years for the Tasmanian Medicare Local to build up its place in the community.³⁹ Mr Edmondson outlined the details of 11 of the projects the Tasmanian Medicare Local works on currently, however he explained that this is a small sample of the 'more than 200 current contracts with Tasmanian health service providers and agencies to deliver joined up primary healthcare services'.⁴⁰ Dr Judith Watson, Chair of the Tasmanian Medicare Local explained the work that had been done to secure the community's trust and through collaboration with stakeholders:

What Medicare Locals were always intended to be about was major system business change, primarily to bolster the power of the primary sector to keep people well and out of hospital—the most economical and sustainable use of the health dollar and better for all Australians. We will be doing this by changing the way in which primary and tertiary sectors interact to service the health needs of the communities, by changing the way in which primary health providers work, communicate and engage to provide the best possible care to all of their communities and by changing the expectation, utilisation and understanding of what communities can and should expect from their primary care system. None of these things happen overnight; indeed, it takes many years of intensive effort of trust and collaboration to achieve many of the changes necessary to effect such changes in balance and focus. We must now make the most of this opportunity to do our best to preserve the service continuity within our state.⁴¹

4.45 A key part of the work undertaken by Medicare Locals is to 'provide better services, improve access to care and drive integration across GP and primary health

39 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 11.

40 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, pp 2–3.

41 Dr Judith Watson, Chair, Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 1.

care services'.⁴² An example of the success of Medicare Locals in this area was provided to the committee by Ms Kathryn Stonestreet, CEO, Southern NSW Medicare Local:

General Practice in Tuross

Tuross Head Surgery is a general practice owned and operated by SNSWML [Southern NSW Medicare Local]. Opened in March 2010, the thriving practice now has more than 1,500 regular patients and three GPs supported by a practice nurse and three receptionists, as well as regular visits by allied health professionals.

The story was very different in 2009 when Tuross Head residents had been without a GP in their town for two years. Recognising this significant gap in primary health services for a community of 2,500 people with an ageing population, limited transport options, and a significant year round visitor population, SNSWML applied for Federal Government funding to establish and operate a general practice in the seaside village. The application for \$210,000 was successful and 12 months later Tuross Head Surgery was open for business.⁴³

4.46 Witnesses expressed strong concerns that with the cessation of funding for Medicare Locals on 30 June 2015, and the uncertainty created by the establishment of new PHNs, continuity of services was at risk. Mr Paul Hersey, CEO South Coastal Perth Medicare Local, explained his concerns about whether the transition would allow for existing services and contracts to continue:

My concern about the transition to Primary Health Networks is that this service continuity needs to be maintained. People accessing services are the most vulnerable in the community and, in many instances, if these types of programs are not available, people will simply not access the healthcare system, which would obviously have a detrimental impact on the individual and, down the line, on the acute care system.

I have gone on the record previously indicating my support for the concept of Primary Health Networks and the opportunities presented through larger organisations, GP-centricity and an ability to take an equal seat at the table with state health and other state-wide bodies. However, my concern in my area is about ensuring a smooth service transition and, in my own case, running a Medicare Local that hopes to transition to a service delivery organisation to continue to be able to deliver those services in spite of losing in excess of \$3 million in core funding.⁴⁴

4.47 The Partners in Recovery Program is another example of a program at risk due to the change from Medicare Locals to PHNs. Mr Darren Carr, CEO of the

42 Australian Government, *A National Health and Hospitals Network for Australia's Future – Delivering better health and better hospitals*, report, 2010, p. 33.

43 Answer to question on notice, Kathryn Stonestreet, CEO Southern NSW Medicare Local, 16 September 2014.

44 Mr Paul Hersey, CEO, South Coast Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 11.

Mental Health Council Tasmania explained the community benefits of the Partners in Recovery Program:

Partners in Recovery is an excellent program. It has made a difference here in Tasmania. In particular, it has made a difference for the people who are at the pointy end of the triangle, so to speak—the people who are the most unwell and are falling through the gaps of current services... Due to eligibility criteria differing from program to program and service to service, consumers who have complex needs and needs that perhaps involve multiple service providers often fall through the gaps. Partners in Recovery has helped...make it far less likely and has helped those people deal with multiple service providers.

My father died of cancer five years ago. Dealing with multiple service providers, as he was dying, was complex and difficult for our family—never mind the fact that I have worked in the cancer field, have a brother who is a doctor and a mum who is very involved. Even then, it was difficult. For people with a severe illness who do not have those fantastic supports...Partners in Recovery has helped those people enormously. We are seeing some great outcomes from Partners in Recovery.⁴⁵

4.48 At Senate Community Affairs Legislation Committee Supplementary Estimates, the Department of Health was unable to give any reassurance that Partners in Recovery would not suffer under the closure of Medicare Locals:

Mr Booth: The Medicare Locals exist until 30 June [2015] and then Primary Health Networks take over. There are a number of areas, in terms of transition, in a number of services which come to an end at the end of that particular period or, as in the case of Partners in Recovery, where the contract goes for a further year and lead agencies in that area are Medicare Locals...The answer is that we are working closely with Medicare Locals and Partners in Recovery consortia to look at how we deal with that. Our key aim with Medicare Locals, in working with them over the next six months, is to ensure that service delivery is prioritised and that there is no reduction in service delivery that they need to do. We would certainly make sure that was happening, as far as we could, with Partners in Recovery.

Senator WRIGHT: So at this stage you are working with them closely, but there is no answer for those organisations.

Mr Booth: Not yet. As we are doing with a number of different areas, we are working with the Medicare Locals; we are working with the consortia to work out the transition period.⁴⁶

4.49 Department of Health officials have emphasised that funding for Partners in Recovery will continue beyond the closure of Medicare Locals, until 30 June 2016.

45 Mr Darren Carr, CEO, Mental Health Council of Tasmania, *Committee Hansard*, 3 November 2014, p. 11.

46 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, pp 35–36.

However when pressed on this subject, officials disclosed that the lead agencies of the majority of the 48 Partners in Recovery Regions are Medicare Locals which are facing closure one year earlier in June 2015.⁴⁷ In fact, an answer to a question on notice demonstrates that 73 percent of Partners in Recovery Regions have Medicare Locals as their lead agency.⁴⁸ This means that that nearly three-quarters of the Partners in Recovery programs being delivered across the country are at risk due to the government's decision to close Medicare Locals.

4.50 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ, described the effect on the community of the uncertainty around whether the services currently organised by Medicare Locals would continue:

The establishment of the smaller number of PHNs in place of the 61 Medicare Locals is creating nervousness within the sector. In particular, the closure of Medicare Locals with no transitional arrangements for rural staff creates an environment of uncertainty. There is also lack of clarity regarding the role and responsibilities of the new PHNs. The current extent of change—for example, to the funding of drug and alcohol services, to disability services, to preventative health initiatives and to primary health care—along with the current uncertainties about funding cuts and short-term contracts, is making effective practice difficult for providers, impacting on clients who are continually transitioning from one service to a new one. Change needs to be rolled out slowly so that people can learn new systems and adapt, but the current level of change from both state and federal governments is overwhelming, having a detrimental impact on consumers. Continuity of care is essential for recovery and wellness.⁴⁹

4.51 The loss of services provided by Medicare Locals will impact on the most vulnerable in the Australian community, including Aboriginal and Torres Strait Islander Australians. Medicare Locals who spoke to the committee told about their work identifying gaps in services, consulting with Aboriginal communities, and building networks and services. For example Mr Vahid Saberi, Chief Executive Officer of the Northern NSW Medicare Local told the committee about work his Medicare Local had undertaken to ensure emergency healthcare services to Aboriginal communities:

...in many of these Aboriginal settlements, the ambulance does not go in without police escort. During and after hours they have no health professionals, so the community is left without any health skills at all during or after hours. They were talking about a trauma that had happened in the community and that they could not respond. It took the ambulance an hour or an hour and a half to get there. So we started the process of doing first aid in Aboriginal communities, which has been a fantastic program.

47 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Committee Hansard*, 8 October 2014, p. 70.

48 Department of Health, *Answer to Question on Notice 12*, 8 October 2014 hearing.

49 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ, *Committee Hansard*, 21 August 2014, p. 11.

We subsequently are working with the Commonwealth Bank for them to be part of this process. We have 13 Aboriginal communities where we have run first aid and we are moving them into mental health first aid. We are using that group to really start doing other things in the community. Subsequent to that, there was a call from a mainstream community in Coraki saying, 'We would really like this as well.' Now we are doing it in small towns.

So a small visit resulted in a movement now of building resilience and capacity in communities. Now the ambulance service has come on board and said, 'We can make some of these people first-aid responders in this community.' That link is so important for us to be able to understand the reality of our region and respond—and there are lots of programs like that.⁵⁰

4.52 In South Australia, other Medicare Locals, such as the North Adelaide Medicare Local, have worked to ensure that Aboriginal stakeholders are included in the Medicare Local service process. Ms Debra Lee, Chief Executive Officer of the North Adelaide Medicare Local, told the committee:

...We ensured that our organisation had a broad and responsive membership base. We set up initially seven membership consortium groups, all of whom were focused around what we knew to be our community population health issues. They were: mental health, palliative care, general practice, older persons in aged care, medical specialists, Aboriginal health, carers and consumers. And, in the last few months, we have expanded those to include disability and childhood, as two new MCGs [Membership Consortium Groups].

Our MCGs ensure that we have the broadest possible input from all of our stakeholders, service providers, organisations and community, which directly feeds our strategic direction and our needs-assessment analysis. We support them to meet and discuss; we simply ask them to each prioritise what they see as being their top three priorities for primary health in their specific areas.⁵¹

4.53 Some examples of services provided to Aboriginal and Torres Strait Islander Australians by Medicare Locals, and which are now at risk due to the closure of the Medicare Locals include:

*North Coast New South Wales Medicare Local*⁵²

North Coast NSW Medicare Local co-ordinate a range of Aboriginal health programs and services across the North Coast including:

50 Mr Vahid Saberi, Chief Executive Officer Northern NSW Medicare Local, *Committee Hansard*, 15 September 2014, p. 27.

51 Ms Debra Lee, Chief Executive Officer North Adelaide Medicare Local, *Committee Hansard*, 9 October 2014, p. 12.

52 Mr Saberi, North Coast Medicare local, *Committee Hansard*, 15 September 2014, p. 26; and www.ncml.org.au/index.php/programs-services (accessed 19 November 2014).

- Bulgalwena General Practice
- Jullums Lismore Aboriginal Medical Service
- Care Coordination and Supplementary Services (CCSS)
- Closing the Gap

*Southern New South Wales Medicare Local*⁵³

- Aboriginal health services including:
- Koori health checks (free health checks in a local general practice)
- Koori Diabetes Days (free diabetes monitoring and treatment)
- Koori Boois (Mums and bubs clinic and playgroup)
- School clinic visits (clinic style health check services for Aboriginal school students)
- Butt out Boondah (tobacco cessation and support)
- Deadly Dads (promotion of fatherhood and grandfatherhood)
- Living strong (healthy lifestyle programs)
- Coordinated Care and Supplementary Services (chronic medical condition management)

*Barwon Medicare Local*⁵⁴

Aboriginal health services, including:

- Closing the Gap
- Indigenous Chronic Disease (providing support to the health sector and better access to health care by Indigenous Australians)
- Indigenous PIP (a gateway service to which patients can access services through the Closing the Gap program)

*Goldfields-Midwest Medicare Local*⁵⁵

- the Closing the Gap (CTG) program which provides on the ground support to clients and assistance to GPs and allied health services to reduce barriers to health care;
- encouraging further use of Telehealth for specialists, general practices, residential aged care facilities or Aboriginal medical services and increase the delivery of health services across the region.

53 www.snswml.com.au/our-health-programs.html (accessed 19 November 2014).

54 www.barwonml.com.au/health-professionals/clinical-services-support (accessed 19 November 2014).

55 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, pp 10–15.

4.54 It is instructive to consider the range of services which are at risk as a result of the government's decision to close Medicare Locals. Appendix 8 illustrates a selection of the services detailed to the committee during its public hearings and included in submissions.

Medicare Local services at risk

4.55 The committee heard evidence from numerous Medicare Locals explaining the confusion resulting from the government's announcement of the closure of Medicare Locals from 1 July 2015. Critically, many Medicare Locals argued that the long term damage to communities would be exacerbated by the uncertainty surrounding the continuation of many services provided exclusively by Medicare Locals.

4.56 During this inquiry the committee received oral evidence from 14 of the 61 Medicare Locals about the valuable services they provide to their communities. Appendix 8 breaks down that information by state to demonstrate the far reach of the likely cuts to Medicare Local services. While this is not an exhaustive list, it provides a snapshot of the valuable programs that are at risk due to the government's decision to close Medicare Locals.

Committee comment

4.57 The scale of the change the government is proposing becomes evident upon reading the long list of complex and essential programs currently being either provided or coordinated by the 14 Medicare Locals consulted in the course of the committee's inquiry.

4.58 The committee is greatly concerned that the way in which the government is managing the closure of Medicare Locals that will result in important community healthcare services being cut. Given the uncertainty created by the closure of Medicare Locals, the committee is concerned that communities will be left in the dark as to what services will be provided by PHNs. The committee is also deeply concerned by the rushed transitional arrangements as discussed earlier in this chapter, given the department's inability to guarantee continuity of important healthcare services around Australia.

4.59 The uncertainty and lack of clear information surrounding the closure of Medicare Locals and the establishment of PHNs is already eroding the work done by the Medicare Locals. The result is likely to be that PHNs will have to duplicate the groundwork work already done by the Medicare Locals. In essence, the government's broken promise not to close Medicare locals will push back by several years the establishment of innovative and integrated primary health organisations. The government has provided no certainty that the roles and services provided by Medicare Locals will be reproduced by PHNs.

Loss of healthcare professionals

4.60 The uncertainty over continuity of contracts and services has already had a negative effect on communities. Several Medicare Locals advised the committee that skilled health professionals had left their communities, simply because their

employment was not guaranteed with the change to PHNs. This was particularly noticeable in evidence from witnesses from regional and rural areas.

4.61 Mrs Nancy Piercy, CEO, Murrumbidgee Medicare Local, told the committee that her Medicare Local had already lost professional staff due to the uncertainty surrounding the move to PHNs. These are staff providing frontline services:

Yes. Two psychologists on Friday and one exercise physiologist yesterday: it is front-line staff we are losing. It is just the uncertainty. We are still very positive within our organisation. We are keeping positive that, depending on the boundaries, we will have a role to play somewhere but we cannot give them a guarantee that we will be a service provider and the job is going to be there. Definitely a lot tell me they are applying and have had interviews in Melbourne. The last ones went to Sydney to Brisbane.

The opportunity for employment in rural areas is not good. Wagga is not bad but that is only a third of the population of our area. It is the smaller areas where we have been able to recruit, particularly allied health professionals, on a part-time basis. We do employ a lot part-time because the services are only needed for smaller communities. We have primary care nurses working over 54 small communities doing care coordination. They live out there and provide to four or five different communities. They are the ones who are asking: 'What will happen to us? Is it in scope with the primary health network for the type of work we are doing to be commissioned? Who is going to be our boss? Who is going to organise services across 54 tiny rural communities with no hospital in them?'⁵⁶

4.62 Mrs Brenda Ryan, CEO of the Goldfields-Midwest Medicare Local also raised the issue of staff leaving as a result of the uncertainty in 2015:

The uncertainty of the future at the moment is concerning with many health professionals considering their options moving into 2015. The late announcement of the boundaries caused some concerns for subcontractors and staff alike. To lose staff at this point in time would be problematic to service communities for the future. The board of the Goldfields-Midwest Medicare Local is highly concerned with maintaining service continuity at the current level. The pressure of reduction in funding has not only put more uncertainty into the mix, but there are many of our staff undertaking two or three roles, which we recognise is unsustainable and untenable.⁵⁷

4.63 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ explained that the uncertainty for staff and professionals also had a massive negative effect on users of the services. In the case of mental health patients who are already vulnerable, the effect of the uncertainty and the severing of their relationship with mental health professionals could be disastrous:

56 Mrs Nancy Piercy, CEO, Murrumbidgee Medicare Local, *Committee Hansard*, 2 October 2014, p. 27.

57 Mrs Brenda Ryan, CEO, Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 10.

...at the consumer level there is a fear about what is going to happen and who is going to be here to provide the service. You have Medicare locals providing allied health staff within the huge region...occupational therapists, social workers and psychologists who move not just within the Townsville and Mackay areas but right out to, for example, Flinders Shire and the Hughenden area. Nobody knows if they are going to have a job past the end of the Medicare locals. They are employed by the Medicare locals to provide the allied health services and they cannot guarantee their clients that they are going to be here to continue that service past 30 June 2015.

That is an awful feeling for somebody, for example, who is living with a mental health issue...Are they going to be retraumatised by having to sit down with a brand new clinician and start going through the process: 'This happened to me when I was 15. This is why I have this issue.' That is a very traumatising process. We know that, for any person who suffers from mental ill health, continuity of care is essential as part of that recovery process. To have a really negative experience with a medical appointment...can set a person back in their recovery significantly...Medicare locals have been able to do that through the provision of umpteen number...of allied health people in this area. Their jobs are now in jeopardy and we do not know what is going to happen to them past 30 June.⁵⁸

Costs of closing Medicare Locals

4.64 The closure of Medicare Locals will result in the loss of staff, contracts, program experience, and community goodwill. While it is difficult to quantify the loss of community goodwill, staff and healthcare services, the committee has been given figures relating to the wind up costs of 10 Medicare Locals. These are detailed in the table below.⁵⁹

58 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ, *Committee Hansard*, 21 August 2014, p. 12.

59 As some staff work part-time, employee numbers in the following table and footnotes may vary with the staff numbers being higher than the FTE numbers.

Table 2—Wind up costs of Medicare Locals (a sample)

Medicare Local	FTE	Wind up costs
Southern NSW Medicare Local	Not supplied	\$1.7 million ⁶⁰
Central Queensland Medicare Local	72	Not supplied ⁶¹
Murrumbidgee Medicare Local	102	\$1 million ⁶²
Bayside Medicare Local	55	\$800 000 ⁶³
Barwon Medicare Local	55	\$2 million ⁶⁴
Loddon Mallee Murray Medicare Local	40	\$1.3 million ⁶⁵
Country North Medicare Local	75	\$1.9 million ⁶⁶
North Adelaide Medicare Local	65	\$2.2 million ⁶⁷
Central Adelaide and Hills Medicare Local	60	\$1.2 million ⁶⁸
Goldfields-Midwest Medicare Local	47.8	\$900 000 ⁶⁹
South Coast Perth Medicare Local	81	Just under \$1 million ⁷⁰
Tasmania Medicare Local	Not supplied	Over \$3 million ⁷¹

60 Ms Kathryn Stonestreet, CEO, Southern NSW Medicare Local, *Committee Hansard*, 16 September 2014, p. 3. The Southern NSW Medicare Local has about 150 employees.

61 Mrs Jean McRuvie, CEO Central Queensland Medicare Local, *Committee Hansard*, 30 September 2014, pp 2–3. The Central Queensland Medicare Local has about 94 employees.

62 Mrs Nancye Piercy, CEO Murrumbidgee Medicare Local, *Committee Hansard*, 2 October 2014, p. 26. The Murrumbidgee Medicare Local has more than 100 private contractors and 120 employees.

63 Dr Elizabeth Deveny, CEO Bayside Medicare Local, *Committee Hansard*, 2 October 2014, p. 27. The FTE count for the Bayside Medicare Local depends on whether both Commonwealth funded services and state funded services are included.

64 Mr Jason Trethowan, CEO, Barwon Medicare Local, *Committee Hansard*, 6 October 2014, p. 2. The Barwon Medicare Local has 85 employees.

65 Mr Matthew Jones, CEO, Loddon Mallee Murray Medicare Local, *Committee Hansard*, 7 October 2014, p. 46. The Loddon Mallee Murray Medicare Local has just over 60 staff, including part time staff. 50 per cent of staff are mental health clinicians.

66 Mr Kim Hosking, CEO Country North Medicare Local, *Committee Hansard*, 9 October 2014, p. 19. The Country North Medicare Local has around 100 employees.

67 Ms Debra Lee, CEO North Adelaide Medicare Local, *Committee Hansard*, 9 October 2014, p. 19. The North Adelaide Medicare Local has about 70 employees.

68 Mr Chris Seiboth, CEO, Central Adelaide and Hills Medicare Local, *Committee Hansard*, 9 October 2014, p. 19.

69 Mrs Brenda Ryan, CEO, Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 11. At 30 May 2014, the FTE for the Goldfields-Midwest Medicare Local was 66.6. As at 10 October 2014 the FTE had fallen to 47.8.

70 Mr Paul Hersey, CEO, South Coast Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 11.

4.65 Mrs Jean McRuvie, CEO of the Central Queensland Medicare Local, told the committee that the Department of Health had appointed McGrathNichol to assess the contingent liabilities of the Medicare Locals:

[McGrathNichol] have been appointed to work out what the contingent liabilities will be, because we have core contracts that go to 2016, and the department is breaking that contract. They are liable under contract law to meet reasonable costs for breaking the contract. Reasonable costs could be the cost of a lease. You might have taken the lease on a building. It could be redundancies for staff. It could be any agreement that you have got with a third party. They need to look at that.⁷²

4.66 Mr Phil Edmondson, CEO Tasmanian Medicare Local, told the committee that the alternative, working to improve the Medicare Locals, would surely be an more cost-effective approach:

What are the costs of a process that arguably may well have been achievable, in our view, in large part with respect to the recommendations in the Horvath review, by some simple rewording of contracts? A few new clauses requiring some changes to the way in which things were happening and advice about perspectives on what was considered to be good versus bad performance may well have allowed organisations like ours to make any changes that were required with some very simple, straightforward and highly progressive activity at the local level, without the need for this major sort of 'throw everything up in the air-everything to the wind' type of approach, which seems to have grown legs.⁷³

4.67 The committee tried unsuccessfully over three further hearings⁷⁴ and numerous questions on notice to obtain from the Department the total cost for the closure of all 61 Medicare Locals. Finally, three weeks after first being asked the question, the Department provided an answer, once again frustrating the committee by providing a highly qualified response:

The Department is not yet in a position to know the cost of winding up those Medicare Locals which need to be wound up.

The Department asked Medicare Locals to determine the types of liabilities and categories that could arise resulting from the termination of the Medicare Local Program, to identify all resources allocated to each of those categories, and to provide those figures to the Department.

71 Mr Phil Edmondson, CEO, Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 12. The Tasmanian Medicare Local as 150 staff. Wind up costs are estimated to be higher for this Medicare Local due to it having \$60 million of additional work through the federal government's Tasmanian Health Assistance Package.

72 Mrs Jean McRuvie, CEO Central Queensland Medicare Local, *Committee Hansard*, 30 September 2014, pp 2–3.

73 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 2 October 2014, p. 11.

74 Including during hearings of the Senate Community Affairs Legislation Committee for Supplementary Estimates.

As a result of this exercise an estimate of \$112 million of liabilities was identified against all categories that might be in scope for consideration. This figure, which was committed under funding agreements put in place under the previous Government, represents the outer limit of the claims which might eventually be made by Medicare Locals.

The actual cost of the changeover from Medicare Locals to Primary Health Networks (PHNs) is expected to be significantly less than this amount.

The Department intends to have more detailed discussions with each individual Medicare Local to finalise claims for reasonable costs in early 2015 after the outcome of the approach to market and subsequent announcement of the successful PHN operators.⁷⁵

The PHN tender process

4.68 There have been a range of uncertainties created by the government's management of the PHN tender process. These uncertainties have created genuine concerns amongst existing Medicare Locals. The committee received evidence of the four following concerns about PHN tender:

- uncertain tender timeline;
- lack of tender process details;
- delayed release and configuration of PHN boundaries; and
- the elusive definition of "market failure".

4.69 On 28 November the Minister for Health released the Invitation To Apply (tender) for the PHN Program, almost a month after the originally scheduled release date. Applications for the PHN Program will close on 27 January 2015.⁷⁶ The Department of Health will hold four industry briefings on the PHN Program tender process on 5, 8, 10 and 11 December 2014 in Sydney, Perth, Melbourne and Brisbane respectively.⁷⁷ The committee notes that this arrangement leaves potential applicants little time to finalise and submit their tender for the PHN Program.

4.70 The committee reserves comment on the PHN tender documents. Evidence provided to the committee has centered on the confusion surrounding the tender process. The committee considers that this evidence of flaws in the government's PHN tender process raises doubts regarding any outcome of the tender process following the close of applications.

PHN tender timeline

4.71 Public information about the timeline for the closure of the Medicare Locals and the establishment of the PHNs has been minimal and often contradictory.

75 Answer to Question on Notice 4, 2 October 2014 hearing.

76 Department of Health website, 'Primary Health Networks – Latest News', www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

77 Department of Health website, 'Primary Health Networks – Latest News', www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

4.72 For example, the first detailed information about the implementation was in the 'Establishment of Primary Health Networks Frequently Asked Questions', published on 11 July 2014. This document advised the tender process would commence in late 2014.⁷⁸ The Department of Health advised the committee on 2 October that the 11 July version of this document was the most recent version,⁷⁹ however the committee has since become aware of a version released on 15 October which supplies some minimal updated information.⁸⁰ The Department of Health's website includes a page called 'Establishment of Primary Health Networks: information session' dated 10 July 2014 and reviewed 15 August 2014 which has a timeline for PHN implementation:

Overview

- March 2014: Medicare Local Review provided to Government
- May 2014: 2014-15 Budget Announcement
- June – July 2014: Information Sessions with key stakeholders
- >December 2014: Invitation to Apply
- 1 July 2015: PHNs commence⁸¹

4.73 Mr Saberi, Chief Executive Officer of the Northern NSW Medicare Local, described the timeframes for the transition to PHNs as he understood it at the committee's hearing on 15 September:

There is an invitation to apply. That will be released in November [2014]. One of the suggestions we have made is that maybe [the Department of Health] can do an expression of interest before the invitation to apply, because if there is only one organisation that is going to apply it would be much easier just to transition them. Writing an ITA [invitation to apply] is quite disruptive and a long process. So if our region stays the same and there was an expression of interest and we were the only applicant for it—if there were two or three that is fine—it would work well to just work with us and transition. It would save a huge amount of money, time and relationships and so forth.

...So, the ITA is in November. That closes before Christmas. The results are in February, and then March-April-May or April-May-June [2015] will be a transition period. That is the intended time frame we have been informed of.⁸²

78 Department of Health, *Establishment of Primary Health Networks – Frequently Asked Questions*, Version 1.2, 11 July 2014, p. 3.

79 Ms Mary McDonald, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 2 October 2014, p. 48.

80 See appendix 6 for a copy of the 15 October version of the FAQ.

81 www.health.gov.au/internet/main/publishing.nsf/Content/phn_presentation

82 Mr Vahid Saberi, CEO, Northern NSW Medicare Local, *Committee Hansard*, 15 September 2104, p. 26.

4.74 The clearest picture of the timeframe for the closure of Medicare Locals and the establishment of the PHNs can be found on the website of the Tasmanian Medicare Local. On a page written after briefings provided by the Department of Health, Mr Phil Edmondson, CEO of the Tasmania Medicare Local provides the following timeline:

- 30 June 2014 - Closure of AML Alliance
- July 2014 - Number of PHNs and boundaries announced
- 1 Nov 2014 - Request for Tender (RFT) issued; industry briefings
- Nov-Dec 2014 - Applicants respond to RFT (six-week period)
- Jan-Feb 2015 - Applicants assessed
- Apr-June 2015 - Establishment of new Primary Health Network: service transition commences
- 30 June 2015 - Medicare Local funding ceases: service transition completed
- 1 July 2015 - PHN becomes operational⁸³

4.75 Mr Edmondson told the committee at its hearing on 4 November that he had heard informally from the Department of Health that the tender for the PHNs would be released towards the end of November 2014, however this advice was not provided in writing.⁸⁴ Asked what formal advice had been provided by the Department, Mr Edmondson explained that:

The only formality is in respect of the words that are on the [Department of Health's] website, and if you read that you will have everything that Medicare Locals have in terms of a defined time line and information.⁸⁵

4.76 During Senate Estimates hearings, Department of Health officials were only able to provide a "hopeful" date for the release of the tender rather than anything certain:

We are aiming to have the tender out towards the end of this year. We are working through process at the moment and policy. At the moment, aiming toward the end of this year and hopefully the end of November is what we have been saying.⁸⁶

83 www.tasmedicarelocal.com.au/about-us/primary-health-networks.

84 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 4.

85 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 12.

86 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 38.

Uncertainty surrounding the tender process

4.77 The practicalities of the tender process for PHNs also appear to be unresolved. During Senate Estimates hearings on 22 October 2014, the officials from the Department of Health advised that they were still working through the following parts of the tender process arrangements:

- Areas of the Department that would participate in assessing the proposals.⁸⁷
- Whether the Department will be able to adequately assess the proposals and finalise the tender process between the receipt of proposals sometime in January and early April. The Department indicated that three months (April–June) is needed for a PHN to become functional.⁸⁸

4.78 While the tender documents have now been released, the committee notes that the time for tendering coincides with the end of year period and this may impact on organisations' ability to prepare applications.

Boundary information

Missed timelines

4.79 At the public hearing on 16 September, Dr Carlson, Moruya General Practitioner; and Chair, Southern New South Wales Medicare Local (SNSWML), told the committee that a key problem with the Medicare Locals preparing to tender for the PHNs was that there was no boundary information available. The Department of Health had earlier advised that the information would be released in July 2014. The date was then extended to August. Dr Carlson told the committee:

We have been informed that it is sitting with the minister now. There has been a recommendation. The longer it goes the harder it is to form those partnerships. For example, say we were going to partner with Illawarra-Shoalhaven. If we want to do that in a collegial fashion and merge with that ML, which is another high-performing ML, that will take us time with the boards to look at the vision and the governance structure, and that is only half the picture. Then we have to collaboratively come up with a vision for the primary health network and how we are going to address the ITA [invitation to apply] and performance measures that they have stated in that. They will be less likely to do that.⁸⁹

87 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 38.

88 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 39.

89 Dr Carlson, Moruya General Practitioner; and Chair, Southern New South Wales Medicare Local, *Committee Hansard*, 16 September 2014, p. 6.

4.80 At the time Dr Carlson spoke to the committee, the boundary information for the Medicare Locals had not been published. After significant delay, the boundary information was released on 15 October 2014 after a decision by the Minister for Health over the final boundaries.⁹⁰

4.81 Despite the delay of over three months, the Department released the PHN Program tender documents on 28 November 2014.

Boundary configurations

4.82 The government's PHN boundary decision reduced the number of primary healthcare organisations from 61 Medicare Locals to 30 PHNs. The Department explained that the figure 30 had come from the findings of the Review.⁹¹

4.83 Patient flows were also part of the consideration for the PHN boundaries. However, the Department indicated at Estimates that cross-border patient flow issues would be a matter to solve on the ground rather than at the boundary planning point:

[The Department of Health] did look at patient flows and we were very aware of patient flows that go across boundaries in a number of areas in the country. I think it is fair to say that the intent for the PHNs and one of the strong drivers we have is the establishment of the clinical networks at a lower level. The purpose of the clinical networks is to assist the patient pathway to improve outcomes for patients at the ground level. We would expect that if there were significant cross-boundary issues then the clinical councils would cooperate with each other and the PHNs would cooperate in looking at those issues. Boundaries are always going to be an issue.⁹²

4.84 However, from the evidence provided at Estimates, it appears that thorough consultation with state and territory governments was not a consideration of setting the PHN boundaries. An example of this lack of consultation prior to the release of the boundaries is demonstrated in the following exchange on the Queensland PHN boundaries:

Senator McLUCAS: Was Queensland Health made aware of the PHN boundaries before they were announced?

Mr Booth: No.

Senator McLUCAS: No?

Mr Booth: We had discussions with state and territory governments around boundaries because we needed to look at hospital flows, but the boundaries

90 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 29.

91 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 29.

92 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 30.

that were released last week were all released to everybody at the same time. There was no prerelease to any party whatsoever.

Senator McLUCAS: But consultation with the states has occurred?

Mr Booth: We talked to states, as we do on a whole series of things, and they had opinions and views. We needed to talk to them about the hospital flows.⁹³

4.85 The reduced number of PHNs is particularly dramatic when considering Australia's larger and more sparsely populated states. For example Western Australia will experience a reduction from eight Medicare Locals to three PHNs. One Western Australia PHN boundary in particular, "Country WA", has an enormous geographical area (approximately 2.5 million square kilometres) with a diverse set of health care issues across a small and often isolated population. Boundary maps for the Medicare Locals and the PHNs are at appendix five. Senator Smith expressed concerns over the reduction in the number of PHNs for Western Australia during Budget Estimates:

In all honesty, I was surprised to see that Western Australia would have one organisation outside the Perth metropolitan area. I owe it to myself as a regional Western Australian senator to discuss this.

How would Mr Horvath or the department justify one network over an area that captures the Kimberley region in the north, with very high levels of Indigenous population; Albany in the far south, with a large non-Indigenous but ageing community; then young families spread across the Western Australian wheat belt and mining towns like Kalgoorlie? How do we envisage an organisation like that working with such variant health needs, big differences in population characteristics and the sheer distance? For those who are not familiar, the Kimberley of Western Australia is at the tip of the Australian continent and Albany fronts the Great Australian Bight. So how do we justify that?⁹⁴

4.86 In answer to Senator Smith, the Department argued that despite the reduction in the number of PHNs, the state would still have adequate representation because one PHN could draw on multiple clinical councils:

The key role there is where the clinical councils come in, in terms of operating at a more local level. Those clinical councils are based on existing WA Country Health Service boundaries. So they all link in with the boundaries that already exist. I take on board what you are saying. It is a huge geographical area but we would see the organisation that runs that being very dependent on the more local intelligence—both clinical and

93 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 33.

94 Senator Dean Smith, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 34.

consumer—that it gets from the clinical councils and the consumer advisory committees in those areas.⁹⁵

4.87 Medicare Locals voiced concerns about the reduction in the number of PHNs, with the most common concern being that the PHNs would have to be much larger and would lose a local focus. Mr Kim Hosking, CEO Country North Medicare Local South Australia argued:

I think the number of primary health networks is one that needs to be worked through. I would safely predict that over time that number will change. As government changes, the number will change. To achieve the goal of [30], which is reducing the numbers by half, we start to create very sizable primary health network regions. In context, you can achieve a considerable amount in an area of high population density. In other areas it starts to not make a lot of sense. A lot of the work that we look at in the health environment is from the UK and about activities that have been done in the UK. They, of course, have created similar sorts of organisations over there. Their ideal population base that they have used, as I understand it, is a population base which sits around 300,000 to 500,000 people. In a country of 67-odd million, that is a lot of organisations. Translated to Australia, that would mean that we, at 61, have fewer by proportion than the UK. Whether you use that as an argument defies my opening statement about not spending too much time looking elsewhere; but, in regions like Western Australia, South Australia, the far west of New South Wales and Queensland, we would be starting to look at very big regions.⁹⁶

4.88 Mrs Nancy Piercy the CEO of the Murrumbidgee Medicare Local compared the size anticipated for the PHNs to that of the 'mega area health services' trialled in NSW:

One of the things that I would say is: learn from the experience of the New South Wales government in establishing mega area health services—which failed, so they came back to local health districts. I managed local health districts. I was in there discussing the return to manageable-sized organisations. Local health districts' size was the way to go in New South Wales, which I know very well from having worked all over it. I think the primary health organisation, whatever we call it, aligned to a local health district would have the greatest potential to achieve... The move towards having one primary health network with maybe two or three local health districts in that primary health network would be—from experience, we know it is very difficult to handle that.⁹⁷

95 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 34.

96 Mr Kim Hosking, CEO Country North Medicare Local South Australia, *Committee Hansard*, 2 October 2014, p. 21.

97 Mrs Nancy Piercy, CEO, Murrumbidgee Medicare Local, *Committee Hansard*, 2 October 2014, p. 21.

4.89 The committee asked the Parliamentary Library to analyse the changed ML-PHN boundaries.⁹⁸ From this analysis several striking features of the PHN boundaries become apparent.

4.90 Firstly, the committee notes the massive expansion in population that PHNs will be required to cover. An average Medicare Local services 355 000 people, whereas an average PHN will be required to service more than double this number, 738 000.⁹⁹ Six PHNs will be required to service populations of more than a million people.¹⁰⁰

4.91 Secondly, there are 12 PHNs which individually will be required to service the geographic area and population currently serviced predominantly by three or more Medicare Locals. Table 3 demonstrates the PHN locations that will be required to cover three or more Medicare Local boundaries.

4.92 Finally, in stark contrast to those 12 PHN areas where there has been a high degree of amalgamation, there are seven PHN boundaries which match identically the equivalent Medicare Local boundary. These PHN areas are:

- Western Sydney
- Nepean Blue Mountains
- South Western Sydney
- North Coast NSW
- Gippsland
- Brisbane North and
- Gold Coast

4.93 The committee notes that while some of these Medicare Local regions have quite large populations, the government has provided no explanation as to why 12 PHNs will experience a very high degree of amalgamation while 7 others will retain an existing Medicare Local boundary.

98 A table of the Parliamentary Library ,

99 All population figures are based on 2011 Census data.

100 These are the Central and Eastern Sydney PHN; the Hunter New England and Central Coast PHN; the North Western Melbourne PHN; the Eastern Melbourne PHN; the South Eastern Melbourne PHN; and the Adelaide PHN.

Table 3—Population comparison of PHNs with Medicare Locals—three to one amalgamations¹⁰¹

Primary Health Network	Medicare Local (percentage population coverage)
New South Wales	
Central and Eastern Sydney	Eastern Sydney (100)
	Inner West Sydney (100)
	South Eastern Sydney (100)
Western NSW	Western NSW (100)
	Murrumbidgee (100)
	Far West NSW (100) ¹⁰²
Hunter New England and Central Coast	Central Coast NSW (100)
	Hunter (100)
	New England (100)
Victoria	
North Western Melbourne	Inner North West Melbourne (100)
	South Western Melbourne (100)
	Macedon Ranges and North Western Melbourne (97) ¹⁰³
Eastern Melbourne	Eastern Melbourne (100)
	Inner East Melbourne (99)
	Northern Melbourne (55) ¹⁰⁴
South Eastern Melbourne	Frankston-Mornington Peninsula (100)
	South Eastern Melbourne (100)
	Bayside (99)
Murray	Loddon-Mallee-Murray (91)
	Goulburn Valley (89)
	Lower Murray (86)
	Hume (60)

101 The table is based on an analysis of the Parliamentary Library. All population figures come from 2011 Census data. Medicare Local boundary information comes from www.medicarelocals.gov.au/internet/medicarelocals/publishing.nsf/Content/digital-boundaries#.VGQNKE0cScV and Primary Health Network boundary information comes from www.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks, (accessed 13 November 2014). A Medicare Local is included in the PHN boundary if more than half of its population would be covered by the new boundary.

102 Also encompasses significant proportions of the Hume (40 percent); Lower Murray (14 percent) and Loddon-Mallee-Murray (9 percent) Medicare Locals.

103 Also encompasses significant proportions of the Northern Melbourne Medicare Local (45 percent).

104 Also encompasses significant proportions of the Goulburn Valley Medicare Local (11 percent).

Primary Health Network	Medicare Local (percentage population coverage)
Grampians and Barwon South West	Barwon (100)
	Grampians (100)
	Great South Coast (100)
Queensland	
Central Queensland and Sunshine Coast	Sunshine Coast (100)
	Wide Bay (100)
	Central Queensland (100)
South Australia	
Adelaide	Northern Adelaide (92)
	Southern Adelaide-Fleurieu-Kangaroo Island (88)
	Central Adelaide and Hills (86)
Western Australia	
Perth South	Fremantle (100)
	Bentley-Armadale (100)
	Perth South Coastal (100)
Country WA	South West WA (100)
	Kimberley-Pilbara (100)
	Goldfields-Midwest (98)

Definition of 'Market Failure'

4.94 The Review's terms of reference included 'assessing processes for determining market failure and service intervention, so existing clinical services are not disrupted or discouraged'.¹⁰⁵ The Review was critical of the Medicare Locals, arguing contrary to government claims that they had focused too much on service delivery. The Review asserted that the stakeholders he had spoken to did not support Medicare Locals providing services, except where there is 'demonstrable market failure, where services do not exist or where there is insufficient access to services (i.e. performing a gap filling role)'.¹⁰⁶

4.95 The Review recommended that '[PHNs] should only provide services where there is demonstrable market failure, significant economies of scale or absence of services'.¹⁰⁷

105 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 3.

106 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 7.

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

4.96 Medical Local representatives who provided evidence to the committee felt that often they had no choice but to become service providers. Mrs Brenda Ryan, CEO of the Goldfields-Midwest Medicare Local, argued that in her Medicare Local's area market failure was a way of life with regular workforce shortages.¹⁰⁸

4.97 The Goldfields-Midwest area effectively demonstrates the need for rural and remote Medicare Locals to make the most efficient choice between 'buying a service versus providing a service'.¹⁰⁹ Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local highlighted the point that drawing on an existing workforce in a remote area is not possible as there are already staffing shortages. Flying in professionals from regional centres is likewise an inefficient option because the cost of contracting services increases substantially:

When you cannot find the workforce, you have to bring a workforce in and that workforce, wherever you bring them in from, comes at a cost. The cost increases whenever you bring in services that are not already there. There are some towns where the reality is that those health care professionals are not going to be there. If you look at small towns such as Laverton, Leonora and Norseman, for example, in the Goldfields of Western Australia, you would not find a social worker there, you would not find a podiatrist there, you would not find a physiotherapist there. They are areas of market failure.

Even employing somebody at the cost of \$55 an hour, it is still costly to send them to Leonora, Laverton and Norseman, et cetera, but when you cannot find that physiotherapist and the other allied health services in the closest major regional town to those much smaller towns, then you have to look further afield. Then you have to start flying in allied health professionals from South Australia or from Perth. They are the people you are paying \$140 an hour or more to sit in a plane, plus accommodation and travel costs. That is market failure—that is where market failure is. I do not believe that anybody really looked clearly at that or even asked the question 'What is the difference between providing a cost in-house versus purchasing a service?'¹¹⁰

4.98 Mr Kim Hosking, CEO, Country North Medicare Local South Australia, observed that his Medicare Local had from the start looked at service provision as a means of solving access problems, and had the support of the Department of Health:

Our belief is that as a Medicare Local we solved market failure in our region in a number of aspects of service provision. There is very little in the way of genuine market out there for delivery of service, so our entity from day one as a Medicare Local and with the acquiescence of the department provided a wide-ranging number of services. We think that route is still

108 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, pp 18–19.

109 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 18.

110 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, pp 18–19.

there for an organisation to provide the necessary services, and so we would seek to tender for those services from the PHN or from whomever is doing the tendering.¹¹¹

4.99 Professor Horvath did not define 'market failure', but he did argue that PHNs 'should be providers of last resort and their decision to directly provide services should require the approval of the Department of Health'.¹¹²

4.100 Mr Stankevicius, CEO, Consumer Health Forum Australia, who attended a PHN information session run by the Department of Health, advised the committee what information there was currently about 'market failure' and the role of the PHNs:

The information we have available to us about the private health networks is that they will only be able to actually provide a service—actually directly provide it themselves—as opposed to purchasing a service in the areas where there is market failure. The government has previously said that market failure is where they can pick up the Yellow Pages—I am not sure who picks up the Yellow Pages anymore—and see if there are any private providers in the area that can provide the particular service. If there are, the PHN would be seen as being a competitor to that service, and the government does not think that a government funded service should compete with a private service. That is when it would say there isn't market failure, because there is an existing player in the market place. Therefore, the PHN cannot provide that service. That is our understanding of it at the moment, but, as I said, that is based on the briefing that we were involved with a few months ago. I have not seen any other details.¹¹³

4.101 This working definition gave Mr Stankevicius cause for concern, especially for rural and regional health consumers who have very limited access to services. He told the committee:

I suppose that one of the specific concerns—we have heard it from our rural and regional consumers—is that market failure has existed for a long time in a lot of rural and remote areas of Australia in terms of even getting a health professional, let alone having a health service provided. That will continue. Does that mean that from the first step we will see PHNs in those areas able to provide those services or will they have to test a market that does not exist before they are allowed to provide that service? Again, they are questions we have not had yet had an answer to.¹¹⁴

111 Mr Kim Hosking, CEO Country North Medicare Local South Australia, *Committee Hansard*, 2 October 2014, p. 26.

112 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 14.

113 Mr Stankevicius, CEO, Consumer Health Forum Australia, *Committee Hansard*, 2 October 2014, p. 8.

114 Mr Stankevicius, CEO, Consumer Health Forum Australia, *Committee Hansard*, 2 October 2014, pp 8–9.

4.102 Mr Hosking, CEO, Country North Medicare Local South Australia advocated a definition of 'market failure' that includes both commercial considerations and quality of service and access:

It would be dangerous to define market failure just in commercial terms. Market failure needs also to be considered in quality of service. So in our experience, we deliver quite a significant sized mental health support to our region. There are no other providers in our region who can currently do that. I guess, in fairness, if somebody came along and was able to put the same resource in that we have put in they could be competitive. But you want to ensure that the service that is supplied is a quality service.

We have a number of small NGOs that deliver mental health support but they do not provide clinical counsel to patients in need. We provide that service because there is nobody else there that can do it. In our experience, in a small community there may be a local psychologist or a local social worker or a counsellor who we have tried to see whether they could perhaps do this service for us, funded by us, in that community but they are already busy. It is very difficult. People from the metropolitan area do not easily move into the country to do a lot of the work because you need a critical mass to make it a worthwhile proposition for you.

Market failure is commercial but, in particular, it is quality as well. That is a very important consideration and it goes back to my comment about variation. People with similar needs across Australia do not necessarily receive the same support.¹¹⁵

4.103 The Department of Health provided the following definition of 'market failure':

Market failure is where the services could not be reasonably purchased within the community. That is largely the common definition. The next step on from that, which I think is what people are probably interested in, is: what is the process going to be for that?¹¹⁶

4.104 However, it appears that this definition is not as straightforward as it first appears. Ms McDonald, Acting Deputy Secretary, advised that there is another term, 'service gap':

Ms McDonald: First of all, in the example you gave of where you cannot get services within an area that is a service gap. A service gap is not market failure. If it is a priority for the community then the role of the PHN—and other players will do this as well—will be to look at how to fill that gap.

Senator DI NATALE: Yes, okay. But if that is not market failure then what is?

115 Mr Kim Hosking, CEO Country North Medicare Local South Australia, *Committee Hansard*, 9 October 2014, p. 17.

116 Ms Mary McDonald, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 2 October 2014, p. 39.

Ms McDonald: Market failure is where you could not find another provider able to come into that area or deliver in that area with funding that the PHN might have to purchase the services.¹¹⁷

4.105 The *Frequently Asked Questions on the Establishment of Medicare Locals* supplies the following advice on a definition of 'market failure':

3.6 What process will be used to determine 'market failure'?

A definition of 'market failure' is currently being considered as part of the policy development process. Further information will be provided in the Approach to Market documentation.

3.7 Will Primary Health Networks be service providers?

PHNs will operate as regional purchasers and commissioners of health services. PHNs will only provide services under exceptional circumstances, including where there is demonstrable market failure.¹¹⁸

4.106 Prior to release of the PHN tender documentation, the Department had not provided a definition of 'market failure'. There has still been no public information provided on 'market failure', a critical element of determining a PHN's role.

Committee comment

4.107 After months of delays, the tender documents were released on 28 November 2014. The committee believes that the delay and confusion in the PHN implementation model will ultimately lead to a poor tender process and a significantly inferior model of primary care integration that is correctly emerging from Medicare Locals.

4.108 It is clear from the Review that primary health organisations of some sort are necessary:

It is clear that many patients continue to experience fragmented health care that negatively impacts on individual health outcomes and increased health system costs. There is a genuine need for an organisation to be charged with improving patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a seamless patient experience.¹¹⁹

4.109 A tender process constructed on an unreasonable timeline is likely to result in PHNs which do not fulfil the role which Professor Horvath outlined and which many Medicare Locals already fulfil. As well as being a substantial waste of public money

117 Ms Mary McDonald, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 2 October 2014, p. 39.

118 *Frequently Asked Questions on the Establishment of Primary Health Networks*, 15 October 2014, p. 4.

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

and resources, a flawed tender process would erode public confidence in PHNs and result in serious problems for primary health care access in communities.

4.110 With respect to the Review's recommendations, the committee cannot see that they justify the wholesale abolition of the Medicare Locals and the establishment of a new system of PHNs. In fact, the committee believes that it would have been far more efficient and cost effective for the government to retain the overall Medicare Locals structure and implement a series of targeted changes, in proper consultation with communities, healthcare stakeholders and Medicare Locals themselves.

4.111 Despite all of this it is clear the government intends to proceed with PHNs.

Recommendation 4

4.112 The committee expresses its concern that the government's decision to abolish 61 Medicare Locals and establish 30 new PHNs is resulting in a loss of frontline services that will see significant cuts to services and programs at the local level. Evidence to the committee demonstrates that Medicare Locals have been improving health outcomes, promoting better integration of primary care services and reducing the need for individuals to seek hospital care.

4.113 If the goal of better integration of primary care is to be achieved, the committee recommends that the Primary Health Network tender must include:

- 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 requirement that the integrity of the data collected by Medicare Locals will be preserved.

4.114 In considering the applications for funding for PHNs the government should have a mind to the success of Medicare Locals in:

- reducing hospitalisations
- improving access to after-hours primary care services
- reducing rates of chronic disease
- reducing smoking rates
- increasing immunisation rates
- improving access to mental health services
- improving access to allied health services

Recommendation 5

4.115 The committee expresses its concern that the government's decision to abolish 61 Medicare Locals and establish 30 new PHNs is resulting in the loss of frontline services and will see significant cuts to services and programs at the local level that are aimed at improving population health, better integration of primary care services and keeping people out of hospital.

4.116 The committee notes the government's insistence on only 30 PHNs has created some PHN boundaries that are unworkable. For example, six PHNs will be required to service populations of more than a million people or cover large geographical areas of up to 2.5 million square kilometres. The committee also notes the estimated cost of this process is up to \$112 million.

4.117 In making this recommendation, the committee is mindful that the sector told the committee of the significant disruption caused by the uncertainty created by the government's decision. Given the importance of this issue, the committee believes it is vital for the government to take the time to get the tender process right and then for Medicare Locals to be allowed sufficient time to submit properly considered applications.

Recommendation 6

4.118 The committee notes the government's ongoing failure to consult with community groups, peak bodies including GPs and allied health, and state and territory governments in relation to Primary Health Networks transition arrangements.

4.119 The committee recommends that the government, as a matter of urgency, ensures certainty in regards to the maintenance of the suite of services supplied by Medicare Locals, particularly in areas of rural and remote Australia where access to medical facilities and services is less comprehensive to the level of access in metropolitan areas.

4.120 The committee also notes the government's consistent failure to meet its own timelines and the anxiety and confusion this has caused across the sector.

Recommendation 7

4.121 The committee recommends that the government must take immediate steps to reinstate funding to Indigenous health organisations and ensure that the particular health challenges facing Aboriginal and Torres Strait Islander Australians are effectively analysed and responded to.

4.122 The committee has grave concerns about the lack of continuity of vital primary healthcare services that is likely to result from the shift from Medicare Locals to PHNs. The committee notes the erosion of the positive programs currently being delivered by Medicare Locals as a direct result of the uncertainty created by the government in its mishandled transition to PHNs. The government must provide

greater certainty for Medicare Locals and their communities regarding the continuity of primary healthcare services.

Chapter 5

Proposed merger of the Organ and Tissue Authority and the National Blood Authority

Introduction

5.1 The initial work of the committee has focused on the concerns arising from the 2014-15 Budget.

5.2 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).

5.3 No justification was given in the National Commission of Audit report for the merger of the OTA and the NBA. The government accepted this recommendation, seemingly without analysis, in the 2014-15 Budget.¹ This chapter examines the effect of the proposed merger.

The Organ and Tissue Authority

5.4 An independent statutory agency established in 2009 under the *Australian Organ and Tissue Donation and Transplantation Authority Act 2008*, the OTA:

- works with state and territory stakeholders to deliver the national reform programme on organ and tissue donation; and
- leads the DonateLife Network, a part of the national reform programme and comprising of DonateLife organ and tissue donation agencies and hospital based staff in 72 hospitals across Australia.²

National Reform Programme

5.5 The National Reform Programme (NRP) was announced by the Australian Government on 2 July 2008 and endorsed by COAG on 3 July 2008. In essence the NRP was 'to implement a world's best practice approach to organ and tissue donation for transplantation.'³ The aims of the NRP include to:

1 Budget 2014-15, Budget Measures, Budget Paper No. 2, p. 70. This two line description is the only reference in the entire budget papers about the merger.

2 Organ and Tissue Authority website, *About Us > Organ and Tissue Authority*, www.donatelife.gov.au/organ-and-tissue-authority-ota.

3 Organ and Tissue Authority website, *About Us > National Reform Programme*, www.donatelife.gov.au/about-us/national-reform-programme.

- increase the capability and capacity within the health system to maximise donation rates; and
- raise community awareness and stakeholder engagement across Australia to promote organ and tissue donation.⁴

5.6 The NRP comprises nine key elements to:⁵

- establish a new national approach and system for organ and tissue donation: a national authority and network of organ and tissue donation agencies;
- establish specialist hospital staff and systems dedicated to organ donation;
- provide new funding for hospitals;
- provide national professional education and awareness;
- provide coordinated, ongoing community awareness and education;
- provide support for donor families;
- establish a safe, equitable and transparent donation and transplantation network;
- national eye and tissue donation and transplantation; and
- undertake additional national initiatives, including living donation programs.⁶

5.7 Since the establishment of the OTA, there has been significant achievement against each element, including a significant increase in organ donation in Australia.

5.8 Prior to the establishment of the OTA in 2009, organ donation levels in Australia were at a record low. The Gift of Life Incorporated has observed that the work of the OTA and its single focus on organ donation has had a dramatic effect on the rate of donation:

Since 2009, there has been a 43% increase in the number of organ donors in Australia (354 in 2012 compared to 247 in 2009) and a 30% increase in the number of transplant recipients (1,053 in 2012 compared to 808 in 2009). So far in 2013, there has been a further 18% increase (334 donors to end October compared to 285 last year).⁷

5.9 Transplant Australia has outlined the direct benefits to the Australian economy from reducing the transplant waiting list:

4 Organ and Tissue Authority website, *About Us > National Reform Programme*, www.donatelife.gov.au/about-us/national-reform-programme.

5 Organ and Tissue Authority website, *About Us > National Reform Programme*, www.donatelife.gov.au/about-us/national-reform-programme.

6 Organ and Tissue Authority website, *About Us > National Reform Programme*, www.donatelife.gov.au/about-us/national-reform-programme#sthash.Txs3ISLi.dpuf.

7 Gift of Life Incorporated, *Organ and Tissue Reform in Australia*, 17 December 2013, www.giftoflife.asn.au/blog/Main_Blog_%28Home_Page%29/tag/AOTDTA/.

Ongoing treatment for patients on the waiting list is not the only cost. There are also socio-economic effects such as loss of employment/income, the breakdown in relationships, absenteeism from education, an increase mental illness, physical and psychological changes, and loss of quality of life.⁸

5.10 In 2006, Kidney Health Australia commissioned a report titled *The Economic Impact of End-Stage Kidney Disease in Australia*. Amongst other findings, Kidney Health Australia reported on the direct cost of dialysis treatment compared to the cost of treatment through a transplant:

Each year, dialysis treatment for a person with end stage kidney disease costs \$84,000. The cost of transplantation from a live donor is \$75,000, with ongoing treatment for the recipient with medications costing about \$11,000 annually. In the case of a deceased donor, the cost of a transplant is \$65,000 with ongoing treatment for the recipient costing about \$11,000 annually.

These are direct costs regarding the transplant. However, what they do not take into account is the benefits to society and the economy. Once a person has received an organ transplant, more often than not they are able to return to a relatively 'normal' lifestyle, which includes returning to employment, playing sport, travelling and family life. In some cases, recipients have gone on to start a family themselves. These benefits to society have a positive impact far broader than the direct financial impact on the health system.⁹

5.11 The benefits of organ transplantation to both the recipient and the broader society are undeniable.

The National Blood Authority

5.12 The National Blood Authority (NBA) is an independent statutory agency within the Health portfolio that manages and coordinates arrangements for the supply of blood and blood products and services on behalf of the Australian Government and state and territory governments. It was established by the *National Blood Authority Act 2003* following the signing of the National Blood Agreement by all state and territory health ministers in November 2002.¹⁰

5.13 The NBA represents the interests of the Australian and state and territory governments, and sits within the Australian Government's Health portfolio. The key role of the NBA is to:

- provide an adequate, safe, secure and affordable supply of blood products, blood related products and blood related services; and

8 Transplant Australia, *Organ and Tissue Donation and Transplantation Resource: The Benefits*, www.transplant.org.au/The-Benefits.html.

9 Transplant Australia, *Organ and Tissue Donation and Transplantation Resource: The Benefits*.

10 National Blood Authority website, *About Us*, www.blood.gov.au/about-nba.

- promote safe, high quality management and use of blood products, blood related products and blood related services in Australia.¹¹

5.14 The work of the NBA involves work with state and territory governments, risk planning in relation to ensuring blood supply, and contracting with suppliers of blood and blood products.¹²

Proposed merger

5.15 In its Phase One Report (March 2014), the National Commission of Audit recommended the consolidation, abolition or merger of a number of government agencies, authorities, companies, boards, councils and committees. The Commission argued that many of these bodies not only duplicated work within the Commonwealth Government, but also duplicated and overlapped the functions of the State Governments.

5.16 Among the bodies identified for merger are the OTA and the NBA. The Commission recommended that these two authorities be 'brought together within the department to harness expertise'.¹³

5.17 The government responded to the recommendations of the Commission of Audit regarding the consolidation of government agencies in its 2014-15 Budget. The Budget outlined the agencies and bodies which would be abolished, merged or consolidated, including the OTA and NBA. The collective 'savings' to be made from the merger, abolishment or consolidation of the agencies identified by the National Commission of Audit are estimated in the Budget to be \$19.4 million over four years.¹⁴

5.18 The proposed OTA/NBA merger is but one of approximately 76 official bodies the government proposes to disband before July 2015.¹⁵ To put the savings from the OTA/NBA merger in context, the \$19.4 million savings figure represents the aggregate figure expected from the abolition of the 76 government bodies.

Evidence from hearings

5.19 As part of its examination of the 'savings' to be made from a merger between the OTA and NBA, the committee held a hearing with each organisation.

5.20 Officials at the hearings advised that work was proceeding on the implementation of a merger and the anticipated savings to be made. However, neither the OTA nor the NBA was able to provide advice on a quantum of savings. The only

11 National Blood Authority website, *About Us*, www.blood.gov.au/about-nba.

12 National Blood Authority website, *About Us*, www.blood.gov.au/about-nba.

13 National Commission of Audit, *Phase One Report*, 2014, p. 211.
www.ncoa.gov.au/report/docs/phase_one_report.pdf.

14 The Department of the Treasury, Budget 2014-15, *Budget Paper No. 2*, p. 70.

15 Minister for Finance, Senator the Hon Mathias Cormann, Media Release, *Delivering A Smaller, More Rational Government*, MC 36/14, 13 May 2014,
www.financeminister.gov.au/media/2014/mr_2014-36.html.

explanation of possible efficiencies came from Mr Leigh McJames, Chief Executive Officer of the NBA:

I cannot quantify those savings. There are a range of options and they are under consideration by government but I can indicate that when we have looked at it there are administrative savings that are not even related to staff. To give you an example, you have two organisations in separate buildings when you bring them together there is a saving in rental space straight off because you cut the number of meeting rooms you require. That has utility savings—you only need one IT system; in terms of governance overhead you reduce the requirement so that instead of having two audit committees you only have one audit committee, you only have one set of auditors, you only have one set of annual reports and so that list goes on. There are the administrative overheads. Some of those efficiencies are already being realised. An example is sets of policies—as an independent statutory authority you have a reasonably large overhead in terms of generating policies to adhere to legislative requirements. One agency will only need one set of policies...¹⁶

5.21 When asked a direct question on notice about potential savings, the NBA could not provide any specific details:

The National Blood Authority, Organ and Tissue Authority and Department of Health are continuing to develop advice for Government that will lead to decisions on implementation of the merger, including any savings. This advice forms part of the deliberative process of Government, and therefore it is inappropriate to release it at this time.¹⁷

5.22 Similarly the OTA could not assist in response to a question on notice which sought documents and information regarding the OTA's work on implementing the merger.¹⁸

5.23 The committee notes with concern that rates of organ and tissue donation in 2014 are trending below 2013 outcomes.¹⁹

Committee comment

5.24 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.

16 Mr Leigh McJames, Chief Executive Officer, National Blood Authority, *Committee Hansard*, 25 September 2014, p. 3.

17 Answer to Question on Notice 1, 25 September 2014 Hearing (NBA), www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Additional_Documents (accessed 13 November 2014).

18 Answer to Question on Notice 5, 4 September 2014 Hearing (OTA).

19 'Monthly Report on Deceased Organ Donation in Australia – October 2014', Australia and New Zealand Organ Donation Registry, Produced 5 November 2014, Data received by ANZOD up to 4 November 2014, <http://www.anzdata.org.au/anzod/updates/ANZOD2014summary.pdf>

5.25 Further, the committee believes that merging the OTA and NBA has the potential to be damaging to the achievement of the aims of the OTA's National Reform Programme. Although it may seem that organs, tissue and blood should, as bodily parts and fluids, be treated in similar ways when it comes to supply for transplant and transfusion, their clinical and administrative management is very different.

5.26 The committee recognises that there is a key difference between the decision to donate organs and tissue as compared to donating blood. The decision to donate blood is a personal one and can be taken individually and acted on easily by the individual on a regular basis. Organ donation from a deceased person, while a personal choice, requires the consent of family.

5.27 The two agencies reflect this difference: the OTA focuses on promoting organ donation; providing education about donation; provides training to medical professionals to assist them in discussing organ donation with patients and their families.²⁰ Critically the OTA provides funding to facilitate retrieval of organs from deceased donors. The NBA on the other hand focuses on contract management so as to ensure blood supply and blood products from the Red Cross and other providers.²¹ Promotion and education about blood donation is outsourced.²² These significantly different roles make it likely that few if any operational efficiencies will result from any merger.

5.28 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.

5.29 The committee understands that work is being undertaken in preparation for the merger of the OTA and NBA, including the compatibility of ICT systems and accounting systems. However the committee believes that it is not too late for this work to be stopped and certainty provided to staff and stakeholders that the two authorities will remain separate. The work done to date has shown that the 'savings' from the merger would be minimal at best. The committee thus questions the value of proceeding with the merger, given that it is a strong possibility that the cost of the work to undertake the merger could be greater than the savings achieved.

5.30 At its hearing in Moruya the committee heard the personal story of Mr Brad Rossiter, a double amputee and organ donation recipient. Mr Rossiter is an advocate for organ donation and tells his story in order to educate others about what this gift of life can mean. Asked for his view of the merger of the OTA and NBA, as someone

20 Organ and Tissue Authority website, About Us > Organ and Tissue Authority, www.donatelife.gov.au/organ-and-tissue-authority-ota.

21 National Blood Authority website, *About Us*, www.blood.gov.au/about-nba.

22 Mr Leigh McJames, Chief Executive Officer, National Blood Authority, *Committee Hansard*, 25 September 2014, p. 8.

who had received an organ donation and who remains involved in the DonateLife promotion and advocacy, Mr Rossiter's answer was very clear:

I would like to think that DonateLife, the Organ and Tissue Authority, remains a single entity, because the work they have done since establishing it in 2009 has been strong. They have really built it up well. I think they should continue to push on as they do and provide awareness, through community efforts and also through hospital services, of increasing organ and tissue donation—by themselves.²³

5.31 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 put at risk the positive work done so far by the OTA, with the consequence that organ donation rates in Australia suffer.

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

5.33 The committee concludes that the government's ideological drive for "smaller government" will unnecessarily jeopardise the work of an agency dedicated to increasing organ donation rates and another whose work ensures the safe supply of blood and blood products and services to the Australian community.

Recommendation 8

5.34 The committee recommends that the government cease its planned merger of the Organ and Tissue Authority and the National Blood Authority.

5.35 The committee could find no evidence that a thorough consideration of the impacts of the merger within either agency or the broader public and health sector had been undertaken. Further, based on evidence gained in hearings, any efficiencies to be achieved are minimal and the risks to each agency continuing to improve upon their achievements to date are high.

Senator Deborah O'Neill

Chair

23 Mr Brad Rossiter, personal capacity, *Committee Hansard*, 16 September 2014, p. 25.

Government Senators' Dissenting Report

1.1 The Coalition members of the Senate Select Committee on Health consider that the 'majority interim inquiry report ("the Report") fails to acknowledge the complex issues regarding the provision of healthcare. This failure is a result of a lack of focus and purpose in the Committee and partisan conduct in the pursuit of its agenda.

Structure of the Committee

1.2 It is the Coalition's view that the Select Committee on Health suffers from the following shortcomings:

- management of Health delivery is an outcome under State jurisdiction. The Terms of Reference do not take into account State management and how the Committee proposes to influence the States regarding outcomes;
- the Terms of Reference also do not mention how the Committee proposes to influence COAG and what outcomes it would take to this process;
- indistinct terms of reference;
- a lack of foreseeable actionable outcomes;
- a scope and scale that duplicates much of the work of the Community Affairs Legislation and Reference Committees;
- an agenda that appears unduly partisan;
- a considerable cost to the tax payer which, in the context of the aforementioned observations, we consider to be unjustifiable; and
- the Terms of Reference are well beyond the Health Department's remit.

Hearing dates and cost

Hearings

1.3 The Committee emphasised that they wished to focus on hearings in regional areas. Of the 13 regional hearings proposed by the Chair –

- 5 have since been cancelled;
- 4 that were scheduled to be full days, were only half days (due to lack of witnesses); and
- 1 has been postponed.

1.4 Therefore despite the Committee's purported focus on regional areas, there is yet to be a full day hearing in a town outside the capital cities.

1.5 The Committee has held 10 hearings in capital cities, including 5 in Canberra. Of the hearings in Canberra, 4 hearings were focussed on witnesses that appeared

before the Community Affairs Committee at Supplementary Estimates in October.¹ Hearings in Canberra also had to be cancelled at the last minute due to lack of witnesses (non-government bodies), or were late to start due to lack of quorum (despite being in Parliament House on a sitting day).

1.6 As the Committee can reach quorum with only Labor and Greens' members present, 10 hearings have been held without Coalition Senators. No Senators outside of Labor, Greens or the Coalition have attended a hearing.

Health expenditure

1.7 There is currently unprecedented pressure on the federal budget due to the \$123 billion in future deficits left by the former Labor Government. Without policy changes, this debt will reach \$667 billion.²

1.8 The Commission of Audit has stated that health care spending is the Commonwealth's single largest long term budget challenge.³ Ten years ago the Australian Government spent \$8 billion on Medicare; in 2014-15 the Australian Government will spend \$19 billion. In 10 years' time this expenditure is projected to be more than \$34 billion.⁴

1.9 The Department of Health submitted that in 2011, Australia's annual real rate of growth of total health expenditure was 4.2 per cent. It stated that this was higher than the average across the OECD, at 3.9 per cent. This placed Australia in the 2nd highest quintile on this measure.⁵

1.10 The Report fails to acknowledge the current pressure on the federal budget or provide any alternative means of maintaining sustainable growth in health expenditure. The report also fails to note that while the Government is seeking to bring health expenditure under control, spending in health is still budgeted to rise substantially in coming years.

\$7 co-payment

1.11 The taxpayer currently funds 263 million free services a year under Medicare. Ten years ago the Government was spending \$8 billion on the MBS, today it's \$19 billion, and in 10 years' time it will be more than \$34 billion. Clearly this is unsustainable.

1 The committee hearing in Melbourne on 8 October 2014 included witnesses from the federal departments of Health, Treasury, Finance and Human Services; all witness who appeared during Supplementary Estimates hearings in October 2014.

2 Commonwealth of Australia, Budget Paper 1, p. 1-1.

3 National Commission of Audit, *Towards responsible government: The report of the National Commission of Audit*, Phase One, pp 99–100; 111–112.

4 Senator the Hon Fiona Nash, Senate Community Affairs Legislation Committee, Budget Estimates, *Committee Hansard*, 2 June 2014, p. 64.

5 Department of Health, *Submission 101*, Senate Community Affairs References Committee, Out-of-Pocket Expenses Inquiry, p. 25.

1.12 Medicare is under unprecedented cost and demand pressures from an ageing population, increased lifestyle-related chronic disease, advances in technology and patterns of use.

1.13 New lower thresholds in the single Medicare safety net will help more people and ensure that safety net benefits are available to people who have serious medical conditions or have prolonged healthcare needs.

1.14 Under current rules doctors are paid an incentive fee to bulk-bill (or charge no more than the Medicare rebate) for a GP consultation to concession card holders, or children under 16. A higher bulk-billing incentive is paid to the doctor if the service is provided in a rural or remote location of \$9.10 for each consultation.⁶

1.15 Under the Government's budget changes, these incentives will still apply if doctors limit their co-payment charge to \$7, and will be renamed the low-gap incentive payment.

1.16 Currently there are multiple Medicare safety nets for out-of-hospital services. From 1 January 2016 a new Medicare safety net will simplify existing safety nets for out-of-hospital services whilst continuing to protect vulnerable patients. The new Medicare safety net will have lower thresholds for most people. This may allow some people to qualify for safety net benefits earlier than under current arrangements.⁷

1.17 In addition to the MBS safety net, concession card holders and children under 16 will only be required to pay the \$7 co-payment, for the first 10 bulk-billed services in any calendar year for either General Practice, out-of-hospital pathology, and out of hospital diagnostic imaging. After this cap has been reached an incentive will be paid to the practitioner to bulk-bill (or charge no more than the Medicare rebate) for future services.⁸

1.18 The Government also provides a safety net limit on the out-of-pocket costs of those at risk of excessive medicine costs. Once a patient hits the PBS Safety Net threshold, they have the cost of their PBS medicines reduced. This is an important principle that has been supported by Governments of both political persuasion over many years. It is an important principle that the Government is seeking to apply consistently to Medicare to ensure it also remains sustainable into the future.

1.19 At present there are 7.6 million Concessional PBS patients in Australia.⁹ In 2012-13 one in five PBS-subsidised prescriptions dispensed through community

6 Department of Health, *Strengthening Medicare*, www.health.gov.au/internet/budget/publishing.nsf/content/budget2014-factsheet-strengthening-medicare, accessed 21 August 2014.

7 Department of Health, Budget 2014-15 <http://budget.gov.au/2014-15/content/glossy/health/download/Health.pdf>, accessed 21 August 2014.

8 Department of Health, *Strengthening Medicare*, [www.health.gov.au/internet/budget/publishing.nsf/content/758402BC42DF82DBCA257CEE0020D480/\\$File/strengthening-medicare.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/content/758402BC42DF82DBCA257CEE0020D480/$File/strengthening-medicare.pdf), accessed 21 August 2014.

9 Department of Health, *Submission 12*, Senate Community Affairs Legislation Committee, Inquiry into the National Health Amendment (Pharmaceutical Benefits) Bill 2014, p. 5.

pharmacies were supplied free of charge to concessional patients who had reached the safety net.¹⁰

1.20 Safety net arrangements will continue to protect very high users of medicines under the Government's proposed budget changes.

Merger of the Organ and Tissue Authority and the National Blood Authority

1.21 The Report also recommends that the Government cease its planned merger of the OTA and NBA. Coalition Senators reject this recommendation as it contradicts the evidence given by the NBA during Committee hearings:

No. If anything, we see the merger as offering opportunities and certainly, in terms of getting staff buy-in, most staff are looking forward to it and do see it is an opportunity...**Some of those efficiencies are already being realised.** [Emphasis added.]¹¹

1.22 And from the OTA on 4 September:

The amalgamation of the National Blood Authority and the Organ and Tissue Authority is predicated on there being continued emphasis and focus on delivery of our program objectives, targets and strategies. The merger, as you would know, entails a commitment from the government to continue the critical clinical supply programs of a national safe blood supply and continued growth in organ and tissue donation, and it is **principally focused on streamlining the Australian Public Service on working out where there can be more efficient use of our administrative arrangements and reduction in duplication.** [Emphasis added.] So we are working carefully and methodically to make sure that those objectives can be achieved and that the merger can take place from 1 July 2015. But our overriding goal in that is to make sure that there is continued delivery of our program objectives and that it is not impacted.¹²

1.23 This merger forms part of the Government's overall strategy to reduce inefficiencies, cut red tape, and build a more productive economy.

Medicare Locals

1.24 Coalition Senators reaffirm the independence and thoroughness of the review of Medicare Locals undertaken by Professor John Horvarth AO, former Chief Medical Officer of Australia. Lack of clarity in what many Medicare Locals are trying to achieve, with considerable variability in both the scope and delivery of activities has resulted in inconsistent outcomes, dispirited stakeholder engagement, poor network cohesion, and reduced sector influence.

10 Department of Health, *Submission 12*, Senate Community Affairs Legislation Committee, Inquiry into the National Health Amendment (Pharmaceutical Benefits) Bill 2014, p. 11.

11 Mr Leigh McJames, Chief Executive Officer, National Blood Authority, *Committee Hansard*, 25 September 2014, pp. 2-3.

12 Ms Yael Cass, Chief Executive Officer, Organ and Tissue Authority, *Committee Hansard*, 4 September 2014, p. 2.

1.25 The Government has accepted the recommendations of the review and will establish Primary Health Networks. Coalition Senators support the Government's focus during this transition period on frontline services.

Recommendations

1.26 The Report focusses on changes to co-payments for health expenditure and fails to address the context and reasons for the changes and the fiscal challenges inherited by the Government. The recommendations provided in the Report focus on a series of reviews that would further delay necessary reforms to health expenditure and further increase the unsustainable burden that growing health costs are having on the federal budget.

Recommendation 1

1.27 That Coalition members of the Committee recommend that the Senate support reforms to improve the sustainability of health expenditure as provided for in the 2014-15 Budget.

Senator Sean Edwards

Liberal Senator for South Australia

Senator Zed Seselja

Liberal Senator for Australian Capital Territory

Senator John Williams

Nationals Senator for New South Wales

Appendix 1

Submissions received by the committee¹

- 1 National Health Performance Authority
- 2 Dr Catherine Pye
- 3 Cootharinga North Queensland - Ability First
- 4 Mr Cliff Weder
- 5 Mr David Gorell
- 6 HealthChange Australia
- 7 Exercise & Sports Science Australia
- 8 Australian Rural Health Education Network
- 9 Palliative Care Australia
- 10 Services for Australian Rural and Remote Allied Health
- 11 Australian Dental Association Inc
- 12 Australasian Podiatry Council
- 13 Cancer Drugs Alliance
- 14 Rural Health Workforce Australia
- 15 PHHAMAQ
- 16 Family Planning NSW
- 17 College of Medicine and Dentistry, James Cook University
- 18 Positive Ageing Taskforce Southern Fleurieu & Kangaroo Island
- 19 Alzheimer's Australia
- 20 The Royal Australian and New Zealand College of Psychiatrists
- 21 The Dental Hygienists' Association of Australia Inc.
- 22 St Vincent de Paul Society National Council of Australia
- 23 NSW Consumer Advisory Group – Mental Health Inc.
- 24 South Australian Government
- 25 Wellspect HealthCare

1 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions

- 26 Australian Association for Academic Primary Care Inc.
- 27 Mr Gil Wilson
- 28 Carers NSW
- 29 Grattan Institute
- 30 Rural Doctors Association of Australia
- 31 Australian Society of Anaesthetists
- 32 MS Australia
- 33 Mr Chris Hamill
- 34 Health Care Consumers Association of the ACT Inc
- 35 Aged and Community Services Australia
- 36 General Practice NSW
- 37 The Royal Australasian College of Physicians
- 38 Youth Affairs Council of South Australia Youth
- 39 Australian Nursing and Midwifery Federation Australian
- 40 Name Withheld
- 41 Social Determinants of Health Advocacy Network
- 42 Benetas
- 43 Australian Healthcare & Hospitals Association
- 44 Queensland Nurses' Union
- 45 The George Institute for Global Health and the Menzies Centre for Health Policy
- 46 Health Consumers' Council of WA
- 47 Allied Health Professions Australia
- 48 Australian Medical Association
- 49 Confidential
- 50 Audiology Australia Ltd
- 51 Speech Pathology Australia
- 52 National Stroke Foundation
- 53 Women's Centre for Health Matters
- 54 Diabetes Australia
- 55 NSW Nurses and Midwives Association NSW
- 56 Australian College of Nursing

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- 57 Leading Age Services Australia Ltd
 - 58 Kidney Health Australia
 - 59 Dietitians Association of Australia
 - 60 Australian Psychological Society (APS)
 - 61 Chiropractors' Association of Australia (National) Ltd
 - 62 National Disability Services
 - 63 Aboriginal Health Council of Western Australia
 - 64 Consumer Reference Group Blue Mountains GP Network
 - 65 Dr Jane Barker
 - 66 Name Withheld
 - 67 Australian Council of Social Service
 - 68 Australian Capital Territory Government
 - 69 Queensland Government
 - 70 Medical Technology Association of Australia
 - 71 National Seniors Australia
 - 72 St Vincent's Health Australia
 - 73 Wakool Indigenous Corporation
 - 74 Consumers Health Forum of Australia
 - 75 GMiA
 - 76 Public Health Association of Australia
 - 77 Illawarra Public Health Society
 - 78 Australian Clinical Trials Alliance
 - 79 Private individual
 - 80 Victorian Health Promotion Foundation (VicHealth)
 - 81 Australian Women's Health Network
 - 82 AML Alliance (In Liquidation)
 - 83 Dr Rachel Mascord
 - 84 Australian Health Promotion Association
 - 85 Doctors Reform Society
 - 86 National Aboriginal Community Controlled Health Organisation
 - 87 Australian meals on Wheels (SA)

- 88 National LGBTI Health Alliance
- 89 Australian Catholic University
- 90 Australian Healthcare Reform Alliance
- 91 Dr Ajeet Singh
- 92 Health Consumers Alliance of South Australia Inc
- 93 Northern Adelaide Medicare Local
- 94 NPS MEDICINEWISE
- 95 Heart Foundation
- 96 HSU National
- 97 Australian Indigenous Doctors' Association Ltd
- 98 Macular Disease Foundation Australia
- 99 Lowitja Institute
- 100 Medicines Australia
- 101 Councils on the Ageing Australia
- 102 Pfizer
- 103 Hepatitis Australia
- 104 City of Marion
- 105 Health Workers Union
- 106 Australian Dental Industry Association
- 107 Elizabeth Dolan, Jennifer Smith, Joahne Brown, Matthew Brown, Sharon Gavioli, Narelle Kelly, Felicity Latchford, Francesca Leaton, Fiona Lotherington, Lee Poole, Kate Robson, Paula Steffensen
- 108 Australian Federation of AIDS Organisations
- 109 Optometry Australia
- 110 Mr Martyn Goddard
- 111 Aboriginal Health Council of South Australia Inc.
- 112 TasCOSS
- 113 Rural Doctors Association of Tasmania
- 114 Mental Health Council of Tasmania
- 115 Royal Australian College of General Practitioners
- 116 Australian College of Rural and Remote Medicine

Appendix 2

Additional information and answers to questions on notice received by the committee¹

Additional Documents

- 1 Tabled by Department of Health (SA) at a public hearing in Adelaide on 9 October. Excerpt - Health portfolio Budget statement 2014-15
- 2 Tabled by Population Health Research Network at a public hearing in Adelaide on 9 October - Evidence-based improvement
- 3 Tabled by the Australian Nursing Federation (SA Branch) at a public hearing in Adelaide on 9 October - Opening comments for the Australian Nursing Federation (SA Branch)
- 4 Tabled by the Aboriginal Health Council of South Australia INC. at a public hearing in Adelaide on 9 October - Submission to Select Committee on Health
- 5 Tabled by VicHealth at a public hearing in Melbourne on 7 October.
- 6 Tabled by School of Rural Health, Faculty of Medicine, Nursing and Health Sciences at a public hearing in Melbourne on 7 October 2014
- 7 Tabled by the School of Rural Health, at a public hearing in Melbourne on 7 October 2014
- 8 Tabled by Colac Area Health at a public hearing in Geelong on 6 October 2014 - Annual Report 2013-2014. The link to the report www.swarh2.com.au/cah/documents?Category=Annual Report
- 9 Tabled by Colac Area Health at a public hearing in Geelong on 6 October 2014 - Quality of Care Report 2013-2014. The link to the report www.swarh2.com.au/cah/documents?Category=Quality Reports
- 10 Tabled by Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch at a public hearing in Launceston on 4 November 2014

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www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Additional_Documents

Answers to Questions on Notice

- 1 Answers to questions on notice - public hearing 28 August 2014, Canberra - Premier of South Australia
- 2 Answers to questions on notice - public hearing 28 August 2014, Canberra - Department of Health
- 3 Answers to questions on notice - public hearing 28 August 2014, Canberra - Department of Treasury
- 4 Answers to questions on notice and in writing - public hearing 4 September, Canberra - Organ and Tissue Authority
- 5 Answers to questions on notice - public hearing 25 September, Canberra - National Blood Authority
- 6 Answers to questions on notice - public hearing 2 October 2014, Canberra, Department of Health
- 7 Answers to questions on notice - public hearing 8 October 2014, Melbourne, Department of Health
- 8 Answer to question on notice - public hearing 16 September 2014, Moruya, NSW - Southern NSW Medicare Local
- 9 Answers to questions on notice - public hearing 8 October 2014, Melbourne - Allied Health Professions Australia
- 10 Answers to questions on notice - public hearing 8 October 2014, Melbourne - Royal Australasian College of Physicians
- 11 Answers to questions on notice - public hearing 9 October 2014, Adelaide - South Australian Department of Health and Ageing
- 12 Answers to questions on notice - public hearing 3 November 2014, Hobart - Social Determinants of Health Advocacy Network (Tasmania)

Appendix 3

Witnesses who appeared before the committee¹

Thursday, 21 August 2014 – Townsville

Cootharinga North Queensland

Mr Brendan Walsh, Chief Executive Officer

Mental Illness Fellowship NQ Inc.

Ms Alison Fairleigh, Area Manager, Townsville

College of Medicine and Dentistry, James Cook University

Associate Professor Sarah Larkins, Director of Research and Postgraduate Education

Supported Options in Lifestyle and Access Services Limited

Ms Cathy O'Toole, Chief Executive Officer

Thursday, 28 August 2014 – Canberra

South Australian Government

The Hon. Jay Weatherill MP, Premier

Department of Health

Mr Richard Bartlett, Acting Deputy Secretary

Ms Kerry Flanagan, Deputy Secretary

Department of the Treasury

Mrs Leesa Croke, General manager, Social Policy Division, Fiscal Group

Mr Peter Robinson, General Manager, Commonwealth-State Relations Division, Fiscal Group

Thursday, 4 September 2014 - Canberra

Organ and Tissue Authority

Ms Yael Cass, Chief Executive Officer

Ms Judy Harrison, Chief Financial Officer

¹ www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings

Monday, 15 September 2014 – Lismore

Northern Rivers Women and Children's Services Inc.

Ms Sandra Handley, Manager, Lismore Women's Health and Resource Centre, Wellbeing and Community Division

Individual statements from public – Those speaking include private individuals, allied health practitioners and medical professionals

Dr Jane Barker, Private capacity

Ms Elizabeth Doolan, Private capacity

Ms Kate Greenaway, Private capacity

Dr Danielle Pirera, Private capacity

Ms Cathy Ridd, Private capacity

Ms Janelle Saffin, Private capacity

Mr Gil Wilson, Private capacity

Northern Rivers Social Development Council

Mr Tony Davies, Chief Executive Officer

University Centre for Rural Health

Professor Lesley Barclay, Director

Dr Michael Douglas, Deputy Director Education

North Coast NSW Medicare Local

Mr Vahid Saberi, Chief Executive Officer

Dr Dan Ewald, Clinical Advisor

Interrelate

Ms Fleur Bradburn, Personal Helpers and Mentors Service Manager

Ms Julie Leete, Area Manager, Lismore

Tuesday, 16 September 2014 – Moruya

Southern NSW Medicare Local

Ms Kathryn Stonestreet, Chief Executive Officer

Ms Jo Risk, Integration and Planning

Dr Martin Carlson, Moruya General Practitioner and Chair SNSWML

Eurobodalla Shire Council

Ms Kathy Arthur, Divisional Manager, Community, Arts and Recreation

Moruya Chiro and Wellness

Mr Ifo Ahlquist, Chiropractor

Mr Brad Rossiter, Private capacity**NSW Nurses' and Midwives' Union**

Mrs Annetee Alldrick, Secretary and Delegate, Shoalhaven Branch

Dr David Rivett, Private capacity**Thursday, 25 September 2014 – Canberra****National Blood Authority**

Mr Leigh McJames, General Manager

Mr Peter Executive Director and Chief Information Officer

Tuesday, 30 September 2014 – Canberra**Central Queensland Medicare Local**

Mrs Jean McRuvie, Chief Executive Officer

Thursday, 2 October 2014 – Canberra**Consumers Health Forum of Australia**

Mr Adam Stankevicius, Chief Executive Officer

Ms Priyanka Rai, Policy and Communications Officer

Tasmania Medicare Local (via teleconference)

Mr Phil Edmondson, Chief Executive Officer

Goldfields-Midwest Medicare Local, Western Australia (via teleconference)

Mrs Brenda Ryan, Chief Executive Officer

Perth South Coastal Medicare Local, Western Australia

Mr Paul Hersey, Chief Executive Officer

Bayside Medicare Local, Victoria

Dr Elizabeth Deveny, Chief Executive Officer

Murrumbidgee Medicare Local, NSW

Mrs Nancye Piercy, Chief Executive Officer

Country North Medicare Local, South Australia

Mr Kim Hosking, Chief Executive Officer

Department of Health

Ms Sharon Appleyard, Assistant Secretary, Primary Health Networks Branch

Ms Mary McDonald, Acting Deputy Secretary

Department of Health

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Ms Mary McDonald, Acting Deputy Secretary

Monday, 6 October 2014 – Geelong

Medicare Local Barwon

Mr Jason Trethowan, Chief Executive Officer

Dr Ajeet Singh, Private capacity

Colac Area Health

Mr Geoff Iles, Chief Executive Officer

Mrs Marg White, Director Community Services

Lorne Community Hospital

Ms Kate Gillan, Chief Executive Officer

Ms Andrea Russell, Acting Chief Executive Officer

Australian Diabetes Educators Association

Ms Tracy Aylen, President

Tuesday, 7 October 2014 – Melbourne

Victorian Medicare Action Group

Ms Meredith Carter, Spokesperson

Benetas

Mr Stephen Burgess, Innovation, Policy and Research Officer

Ambulance Employees Australia Victoria

Mr Danny Hill, Assistant Secretary

Victorian Health Promotion Foundation (VicHealth)

Dr Bruce Bolam, Executive Manager, Programs Group

Federation of Rural Australian Medical Educators

Professor Judith Walker, Chair

Australian Medical Association (Victoria) Limited

Dr Anthony Bartone, President

Loddon Mallee Murray Medicare Local

Mr Matthew Jones, Chief Executive Officer

Wednesday, 8 October 2014 – Melbourne

Royal Australasian College of Physicians

Professor Nicholas Talley, President

Dr Nick Buckmaster, Policy and Advocacy Committee

Services for Australian Rural and Remote Allied Health

Mr Rod Wellington, Chief Executive Officer

Mr Rob Curry, Deputy Chair (via teleconference)

Australasian College of Emergency Medicine

Dr Anthony Cross, President

Ms Alana Killen, Chief Executive Officer

Dr Simon Judkins, Victorian Councillor

Grattan Institute

Dr Stephen Duckett, Director, Health Program

Mr Peter Breadon, Health Fellow

Allied Health Professions Australia

Ms Lin Oke, Executive Director

Mr Damian Mitsch, Director

Australian Diagnostic Imaging Association

Dr Christian Wriedt, President

Ms Pattie Beerens, Chief Executive Officer
Mr Chris Kane, Senior Policy Adviser

Department of Health

Ms Kerry Flanagan, Deputy Secretary

Ms Mary McDonald, Acting Deputy Secretary (via teleconference)

Mr Richard Bartlett, Acting Deputy Secretary (via teleconference)

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division
(via teleconference)

Treasury (via teleconference)

Mr Peter Robinson, General Manager, Commonwealth-State Relations Division

Mr Rob Montefiore Gardner, Manager, Health and Disability Unit

Department of Finance (via teleconference)

Mr Mark Thomann, First Assistant Secretary, Social Policy Division

Mr Nicholas Hunt, Assistant Secretary, Budget Group

Department of Human Services

Mr Barry Sandison, Deputy Secretary

Thursday, 9 October 2014 – Adelaide

Department of Health and Ageing (South Australia)

Mr Steve Archer, Deputy Chief Executive, Finance and Business Services

Mr Jamin Woolcock, Chief Finance Officer

Ms Skye Jacobi, Director, Intergovernment Relations and Ageing

Medicare Locals (South Australia)

Mr Kim Hosking, Chief Executive Officer, Country North SA Medicare Local

Ms Debra Lee, Chief Executive Officer, Northern Adelaide Medicare Local

Mr Chris Seiboth, Chief Executive Officer, Central Adelaide and Hills

Population Health Research Network

Professor Brendan Kearney, Chair, Management Council

Dr Merran Smith, Chief Executive Officer

Australian Nursing and Midwifery Federation (SA Branch)

Mr Rob Bonner, Director, Operations and Strategy

Ms Jennifer Hurley, Manager, Professional Programs

Adjunct Associate Professor Elizabeth Dabars AM, CEO and Secretary

University Department of Rural Health

Associate Professor Martin Jones, Director

Aboriginal Health Council of South Australia

Mr Shane Mohor, Acting Chief Executive Officer

Ms Amanda Mitchell, Health Development Coordinator

Mr Paul Ryan, Senior Project Officer, Member Support

Health Consumers Alliance of South Australia

Ms Stephenie Miller, Executive Director

Mr Michael Cousins, Manager, Policy and Advocacy

Friday, 10 October 2014 – Perth

Health Consumers' Council of Western Australia

Dr Martin Whitely, Acting Executive Director

Dr Ann Jones, Policy Officer

Medicare Locals Western Australia

Mr Paul Hersey, Chief Executive Officer, Perth South Coastal

Ms Brenda Tyan, Chief Executive Officer, Goldfields-Midwest (via teleconference)

Curtin University, Western Australia

Professor Mike Daube, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; Director, McCusker Centre for Action on Alcohol and Youth

Western Australian Centre for Rural Health

Professor Sandra Thompson, Director

Associate Professor Judith Katzenellenbogen, Research Associate Professor

Monday, 3 November 2014 – Hobart

Dr Robert Ware, Private capacity

Mental Health Council Tasmania

Mr Darren Carr, Chief Executive Officer

Ms Elida Meadows, Policy and Research Officer

Royal Australian College of General Practitioners

Dr Bastian Seidel, Deputy Chair, Tasmanian Faculty

Mr Martyn Goddard, Private capacity

Social Determinants of Health Advocacy Network

Ms Miriam Herzfeld, Convenor

TasCOSS

Dr Pauline Marsh, Policy Officer

Australian Medical Association Tasmania

Professor Tim Greenaway, President

Aged and Community Services Tasmania

Mr Darren Mathewson, Chief Executive Officer

Tuesday, 4 November 2014 – Launceston

Tasmanian Medicare Local

Mr Phil Edmondson, Chief Executive Officer

Australian Nursing and Midwifery Federation Tasmanian Branch

Mrs Neroli Ellis, Branch Secretary

University of Tasmania

Dr Martin Harris, Lecturer, Centre for Rural Health

Mr Stuart Auckland, Lecturer and Program Manager, Centre for Rural Health

Rural Doctors Association of Tasmania (via teleconference)

Dr Paul Fitzgerald, Treasurer

Family Based Care Association North West Inc.

Ms Justine Barwick, Operations Manager

Appendix 4
Establishment of Primary Health Networks
Frequently Asked Questions
Version 1.2 – last updated 11 July 2014

Establishment of Primary Health Networks
Frequently Asked Questions
Version 1.2 – last updated 11 July 2014

1. Why has a decision to establish Primary Health Networks been made?

The Coalition's *Policy to Support Australia's Health System* committed to a Review of Medicare Locals (the Review). The Review was undertaken by Professor John Horvath AO (former Commonwealth Chief Medical Officer) and was provided to Government in March 2014.

The Review provided independent advice on all aspects of a Medicare Local's structure, operations and functions, as well as options for future directions.

The Review found that many patients were continuing to experience fragmented and disjointed health care that negatively impacted on health outcomes and increased health system costs. It also identified a genuine need for an organisation that could link up the parts of the health system to improve outcomes and productivity.

The Review recommended replacing Medicare Locals with a smaller number of Primary Health Organisations and not funding a national body.

The Government has determined that these new organisations will be called Primary Health Networks (PHNs).

2. Will the Review report be released to the public, and if so, where can I find a copy?

The report has now been made public and is available at the following location:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/medicare-locals>

3. What are Primary Health Networks?

PHNs will be efficient corporate organisations responsible for improving patient outcomes in their local areas by ensuring that services across the primary, community and secondary sectors align and work together in the interest of patients.

4. What is the difference between Primary Health Networks and Medicare Locals?

PHNs will be different from Medicare Locals in many ways:

- They will provide more efficient corporate structures that reduce administrative cost to ensure funding goes to provide frontline services to benefit patients.
- They will offer savings through economies of scale and greater purchasing power, have better planning capacity and increased authority to engage with Local Hospital Networks (LHNs) and jurisdictional governments.
- PHNs will have greater local GP involvement to ensure optimal patient care. GPs will lead Clinical Councils and have a direct say in the activities of PHNs.

- Community Advisory Committees will work with Clinical Councils to ensure local consumer engagement, patient-centred decision-making, and PHN accountability and relevance.
- PHNs will not be providers of health services. Instead, they will be regional purchasers of health services with the flexibility to stimulate innovative public and private health care solutions to improve frontline services and better integrate health service sectors.

5. When will Commonwealth funding for Medicare Locals cease?

Commonwealth funding to Medicare Locals will cease on 30 June 2015.

6. When will the Primary Health Networks become operational?

PHNs will become operational from 1 July 2015, with an establishment and transition-in period from early 2015.

7. How many Primary Health Networks will there be?

There will be fewer PHNs than Medicare Locals. The number of PHNs is yet to be determined.

8. How will the level of funding for Primary Health Networks be determined?

Funding for the PHNs is being considered as part of the PHN policy development process.

9. How will the boundaries of the Primary Health Networks be determined?

Boundaries of the PHNs, as well as their Clinical Councils and Community Advisory Committees, will align with LHNs. This will facilitate collaborative working relationships and reduce duplication of effort. Boundaries are being established with consideration to population size, LHN alignment and patient flow.

10. When will information on boundaries be released?

Boundaries for PHNs are currently being considered as part of the policy development process. Information on boundaries will be released well in advance of the ITA.

11. What will be the role of the Clinical Councils and Community Advisory Committees?

Clinical Councils and Community Advisory Committees will provide local engagement, accountability and relevance for PHNs. Specific roles will be considered as part of the PHN policy development process.

12. Will PHNs need to establish a separate Clinical Council or Community Advisory Committee if the LHN in the region already has existing community or clinical engagement mechanisms?

The Department has discussed existing community and clinical engagement structures with state and territory governments and intends to avoid duplication, where possible.

13. How will GPs be involved with PHNs?

GPs will be involved in PHNs through Clinical Councils. These Councils will be GP-led.

14. Will GP engagement and support be an internal and core role for PHNs?

GP engagement and practice support will be a core role of PHNs. It is expected that this function will be delivered 'in-house' by PHNs instead of being out-sourced, however this may be a business decision for PHNs.

15. How will allied health professionals be involved with PHNs?

The involvement of allied health professionals will be encouraged by PHNs through Clinical Councils.

16. What will the selection process for Primary Health Networks involve?

PHN operators will be selected through a transparent, competitive, open tender process.

17. Who can apply to become a Primary Health Network?

The Invitation to Apply (ITA) will be open to public and private organisations.

18. When will the selection process for Primary Health Networks take place?

The selection process for PHNs is expected to commence late 2014.

19. Will industry briefings take following the release of the ITA?

The department will conduct industry briefings shortly after the release of the ITA.

20. How will Primary Health Networks work with Local Hospital Networks?

PHNs, through their Clinical Councils, will be aligned to LHNs to facilitate collaborative working relationships, reduce duplication of effort, and increase their ability to purchase care for the communities they serve. PHNs will be expected to work with LHNs in population health planning.

21. Will Primary Health Networks be service providers?

PHNs will operate as regional purchasers of health services. PHNs will only provide services under exceptional circumstances, including where there is demonstrable market failure.

22. What process will be used to determine 'market failure'?

A definition of 'market failure' is currently being considered as part of the policy development process. Further information will be provided in the ITA documentation.

23. What role will preventive health activities play in PHNs?

PHNs will have a role in population health assessment to ensure patients can access the frontline services they require, which could include preventive health services if determined appropriate.

24. How can consumers be involved in Primary Health Network decision making?

PHNs will be required to establish Community Advisory Committees to ensure that PHN decisions are patient-centred and address the needs of the community.

25. How will the performance of Primary Health Networks be measured?

PHNs will operate under an outcome focused performance management contract with the Department of Health.

26. What will happen to staff and health professionals currently working at Medicare Locals?

Medicare Locals were established as independent companies limited by guarantee. As such, the business decision to continue or cease operations rests with each Medicare Local. It is expected that the new PHNs will provide opportunities for some staff currently employed by Medicare Locals.

27. What will happen to services currently directly delivered by Medicare Locals?

Medicare Locals will continue to receive Commonwealth funding until 30 June 2015. Service continuity is a priority in the establishment of PHNs and the Department of Health will work with Medicare Locals and PHNs to minimise disruption to services and patient care. It would be expected that the majority of existing Medicare Local frontline services would be transferred to the PHN purchasing environment.

28. Will the organisations currently funded by Medicare Locals receive ongoing funding via Primary Health Networks?

It is anticipated that an establishment and transition-in period for PHNs from early 2015 will support transfer of activities that meet community needs from Medicare Locals to the new PHN purchasing environment prior to 1 July 2015. PHNs will be required to ensure that any subcontracting arrangements are contestable.

29. How will the review of the delivery of after hours services be conducted?

The review on after hours (as recommended in the Review of Medicare Locals) will be a considered as separate process and information on the approach and Terms of Reference will be forthcoming.

30. What will happen in relation to Medicare Locals accreditation?

With the introduction of PHNs, Medicare Locals are no longer required to be accredited under the MLA Scheme.

31. What happens now that the Australian Medicare Local Alliance (AML Alliance) has closed?

With the cessation of Commonwealth funding to the AML Alliance as of 30 June 2014, the department has established a Medicare Locals Network Support Team to work directly with the network to ensure appropriate support during 2014-15.

The Network Support Team will provide communications, with a focus on facilitating best practice sharing and service continuity planning in the lead up to the establishment of PHNs from 1 July 2015. The team can be contacted through the new mlsupport@health.gov.au inbox and MELVIN.

32. Will the Commonwealth fund a new national body for Primary Health Networks?

The Commonwealth will not be funding a national body for PHNs.

If you have a question that has not been addressed above, please contact the department via email at phn@health.gov.au

Appendix 5
Medicare Local and Primary Health Network boundary maps

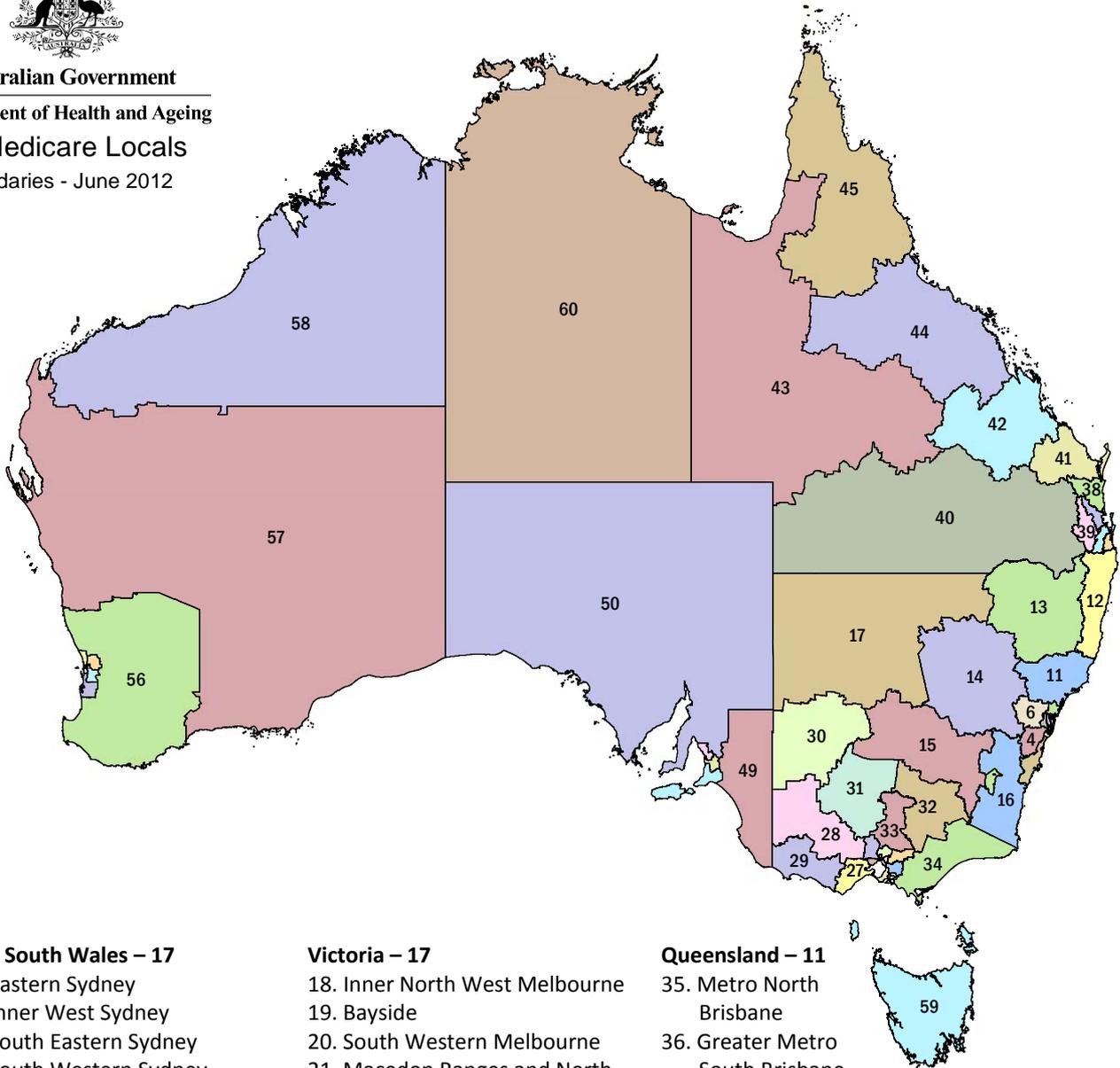


Australian Government

Department of Health and Ageing

61 Medicare Locals

Boundaries - June 2012



New South Wales – 17

1. Eastern Sydney
2. Inner West Sydney
3. South Eastern Sydney
4. South Western Sydney
5. Western Sydney
6. Nepean – Blue Mountains
7. Northern Sydney
8. Sydney North Shore and Beaches
9. Central Coast NSW
10. Illawarra – Shoalhaven
11. Hunter
12. North Coast NSW
13. New England
14. Western NSW
15. Murrumbidgee
16. Southern NSW
17. Far West NSW

Northern Territory – 1

60. Northern Territory

Australian Capital Territory – 1

61. Australian Capital Territory

Victoria – 17

18. Inner North West Melbourne
19. Bayside
20. South Western Melbourne
21. Macedon Ranges and North Western Melbourne
22. Northern Melbourne
23. Inner East Melbourne
24. Eastern Melbourne
25. South Eastern Melbourne
26. Frankston – Mornington Peninsula
27. Barwon
28. Grampians
29. Great South Coast
30. Lower Murray
31. Loddon – Mallee – Murray
32. Hume
33. Goulburn Valley
34. Gippsland

South Australia – 5

46. Northern Adelaide
47. Central Adelaide and Hills
48. Southern Adelaide – Fleurieu – Kangaroo Island
49. Country South
50. Country North

Queensland – 11

35. Metro North Brisbane
36. Greater Metro South Brisbane
37. Gold Coast
38. Sunshine Coast
39. West Moreton – Oxley
40. Darling Downs – South West QLD
41. Wide Bay
42. Central Queensland
43. Central and North West QLD
44. Townsville – Mackay
45. Far North QLD

Western Australia – 8

51. Perth Central East Metro
52. Perth North Metro
53. Fremantle
54. Bentley – Armadale
55. Perth South Coastal
56. South West WA
57. Goldfields – Midwest
58. Kimberley – Pilbara

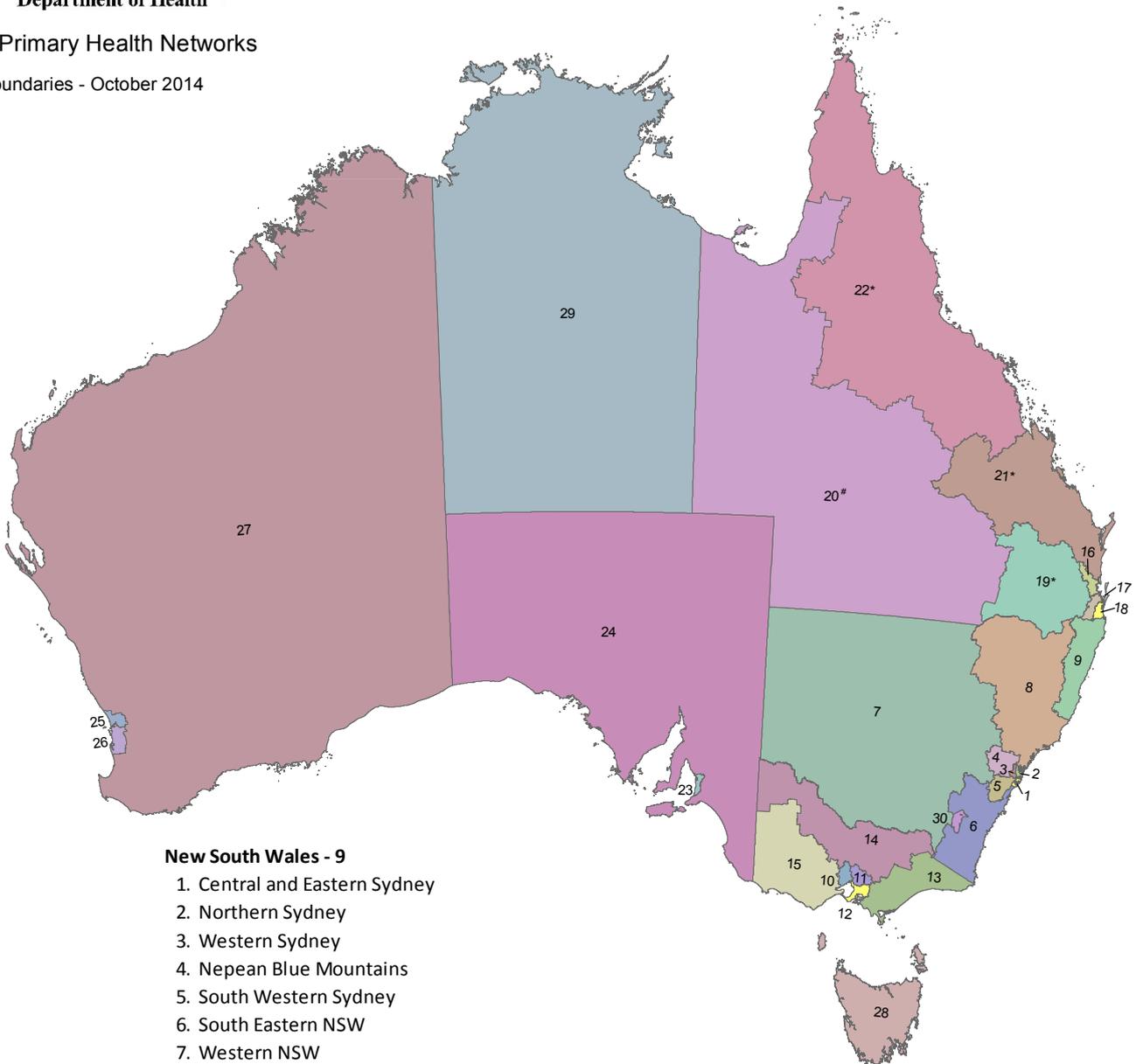
Tasmania – 1

59. Tasmania



30 Primary Health Networks

Boundaries - October 2014



New South Wales - 9

- 1. Central and Eastern Sydney
- 2. Northern Sydney
- 3. Western Sydney
- 4. Nepean Blue Mountains
- 5. South Western Sydney
- 6. South Eastern NSW
- 7. Western NSW
- 8. Hunter New England and Central Coast
- 9. North Coast

Victoria - 6

- 10. North Western Melbourne
- 11. Eastern Melbourne
- 12. South Eastern Melbourne
- 13. Gippsland
- 14. Murray
- 15. Grampians and Barwon South West

Queensland - 7

- 16. Brisbane North
- 17. Brisbane South
- 18. Gold Coast
- 19. Darling Downs and West Moreton *
- 20. Western Queensland #
- 21. Central Queensland and Sunshine Coast *
- 22. Northern Queensland *

South Australia - 2

- 23. Adelaide
- 24. Country SA

Western Australia - 3

- 25. Perth North
- 26. Perth South
- 27. Country WA

Tasmania - 1

- 28. Tasmania

Northern Territory - 1

- 29. Northern Territory

Australian Capital Territory - 1

- 30. Australian Capital Territory

This Primary Health Network could be bid for separately or as an extension of any of the three surrounding Primary Health Networks as indicated by *

Appendix 6
Frequently Asked Questions on the
Establishment of Primary Health Networks

(Version as at 15 October 2014)



Australian Government

Department of Health

Frequently Asked Questions on the Establishment of Primary Health Networks

These Frequently Asked Questions have been developed to provide information regarding the establishment of Primary Health Networks. Please note that this document should not be relied upon to inform responses to the Approach to Market.

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2	Continuity of services.....	3
3	Role and function of Primary Health Networks.....	3
4	Boundaries and funding.....	5
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6	Approach to Market.....	6
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1 2014-15 Budget announcements

1.1 Why has a decision to establish Primary Health Networks been made?

The Government committed to a Review of Medicare Locals (the Review). The Review was undertaken by Professor John Horvath AO (former Commonwealth Chief Medical Officer) and was provided to Government in March 2014.

The Review provided independent advice on all aspects of a Medicare Local's structure, operations and functions, as well as options for future directions.

The Review found that many patients were continuing to experience fragmented and disjointed health care that negatively impacted on health outcomes and increased health system costs. It also identified a genuine need for an organisation that could link up the parts of the health system to improve outcomes and productivity.

The Review recommended replacing Medicare Locals with a smaller number of Primary Health Organisations and not funding a national body.

The Government has determined that these new organisations will be called Primary Health Networks (PHNs).

1.2 Will the Review report be released to the public, and if so, where can I find a copy?

The report has been made public and is available at the [Department of Health's website](#).

1.3 When will the Primary Health Networks become operational?

PHNs will become operational from 1 July 2015, with an establishment and transition-in period from early 2015. Australian Government funding will transfer from Medicare Locals to PHNs on 1 July 2015.

1.4 What will happen to staff and health professionals currently working at Medicare Locals?

Medicare Locals were established as independent companies limited by guarantee. As such, the business decision to continue or cease operations rests with each Medicare Local. It is expected that the new PHNs will provide opportunities for some staff currently employed by Medicare Locals.

1.5 What will happen in relation to Medicare Locals accreditation?

With the introduction of PHNs, Medicare Locals are no longer required to be accredited under the MLA Scheme.

1.6 What advice is available to Medicare Locals?

The Department of Health (the department) has established a Medicare Locals Network Support Team to work directly with the network to ensure appropriate support during 2014-15.

The Network Support Team will provide communications, with a focus on facilitating best practice sharing and service continuity planning in the lead up to the establishment of PHNs from 1 July 2015. The team can be contacted through the new [ML support inbox](#).

1.7 How will the review of the delivery of after hours services be conducted?

A review of the delivery of after hours services was recommended in the Review of Medicare Locals. The Review will focus on existing after hours primary health care arrangements, including the after hours GP helpline and services that are currently funded and supported by Medicare Locals. The Review is being conducted by Professor Claire Jackson, a respected general practitioner, educator and researcher. The Review commenced on 19 August 2014, with recommendations expected to be made to Government by 31 October 2014. Consultations are being held with peak primary health care organisations.

2 Continuity of services

2.1 What will happen to services currently directly delivered by Medicare Locals?

Medicare Locals will continue to receive Commonwealth funding until 30 June 2015. Service continuity is a priority in the establishment of PHNs and the department will work with Medicare Locals and PHNs to minimise disruption to services and patient care. It would be expected that, where appropriate, existing Medicare Local frontline services would be transferred to the PHN purchasing environment.

2.2 Will the organisations currently funded by Medicare Locals receive ongoing funding via Primary Health Networks?

It is anticipated that an establishment and transition-in period for PHNs from early 2015 will support transfer of activities that meet community needs from Medicare Locals to the new PHN purchasing environment prior to 1 July 2015. PHNs will be required to ensure that any subcontracting arrangements are contestable.

3 Role and function of Primary Health Networks

3.1 What are Primary Health Networks?

PHNs are being established to improve the efficiency and effectiveness of medical services delivered to individual patients and funded by the Commonwealth.

PHNs will achieve this by working directly with general practitioners, other primary care providers, secondary care providers and hospitals to ensure improved outcomes for patients as a result of:

- more effective services provided for identified groups of patients at risk of poor outcomes; and
- better coordination of care across the local health system with patients requiring assistance from multiple providers receiving the right care in the right place at the right time.

3.2 What is the difference between Primary Health Networks and Medicare Locals?

PHNs will be different from Medicare Locals in many ways:

- They will be outcomes focused to improve the efficiency and effectiveness of medical services delivered to individual patients and funded by the Commonwealth.
- They will provide more efficient corporate structures that reduce administrative cost to ensure funding goes to provide frontline services to benefit patients.

- They will create savings through economies of scale and greater purchasing power, have better planning capacity and increased authority to engage with Local Hospital Networks (LHNs) and jurisdictional governments.
- PHNs will have greater local GP involvement to ensure optimal patient care. GPs will lead Clinical Councils and have a direct say in the activities of PHNs.
- Clinical Councils and Community Advisory Committees will ensure local engagement and patient-centred decision-making.
- PHNs will not be providers of health services. Instead, they will be regional purchasers of health services, and providers only in exceptional circumstances, with the flexibility to stimulate innovative public and private health care solutions to improve frontline services and better integrate health service sectors.

3.3 How will GPs be involved with Primary Health Networks?

GPs will be involved in PHNs through Clinical Councils. These Councils will be GP-led and provide a direct link between clinicians and the PHN Board to ensure effective decision making, particularly with reference to LHN relationships and developing clinical care pathways.

3.4 How will allied health professionals be involved with Primary Health Networks?

While the Review of Medicare Locals identifies the role of GPs as central, it also recognised the important role of allied health professionals in multi-disciplinary teams in the primary care system. It is expected that the Clinical Councils will consist of representatives of all relevant parts of the health system, including allied health.

3.5 How will Primary Health Networks work with Local Hospital Networks?

PHNs will be aligned to LHNs to facilitate collaborative working relationships with public and private hospitals to reduce duplication of effort, and increase their ability to purchase care for the communities they serve. PHNs will be expected to work with LHNs in population health planning.

3.6 What process will be used to determine 'market failure'?

A definition of 'market failure' is currently being considered as part of the policy development process. Further information will be provided in the Approach to Market documentation.

3.7 Will Primary Health Networks be service providers?

PHNs will operate as regional purchasers and commissioners of health services. PHNs will only provide services under exceptional circumstances, including where there is demonstrable market failure.

3.8 What role will preventive health activities play in Primary Health Networks?

PHNs will have a role in population health assessment to ensure patients can access the frontline services they require, which could include preventive health services if determined appropriate.

3.9 How can consumers be involved in Primary Health Network decision making?

PHNs will be required to establish Community Advisory Committees to ensure that PHN decisions are patient-centred and address the needs of the community.

3.10 How will the performance of Primary Health Networks be measured?

PHNs will operate under an outcome focused performance management contract with the department.

4 Boundaries and funding

4.1 How many Primary Health Networks will there be?

The Minister for Health, the Hon Peter Dutton MP, approved a total of 30 PHNs, the boundaries for which were released on 15 October 2014.

4.2 How were the boundaries of the Primary Health Networks determined?

Boundaries of the PHNs align with LHNs, or clusters of LHNs. This will facilitate collaborative working relationships and reduce duplication of effort. In determining boundaries, a number of factors were considered, including population size, LHN alignment, state and territory borders, patient flow, stakeholder input and administrative efficiencies.

4.3 How will the level of funding for Primary Health Networks be determined?

Funding for the PHNs is being considered as part of the PHN policy development process. It is expected that information on the level of funding for PHNs will be included in the Approach to Market documentation.

5 Governance

5.1 What will be the role of the Clinical Councils and Community Advisory Committees?

Clinical Councils and Community Advisory Committees will ensure local engagement and patient-centred decision-making and will report to the PHN Board. Specific roles will be considered as part of the PHN policy development process.

5.2 Will PHNs need to establish a separate Clinical Council or Community Advisory Committee if the LHN in the region already has existing community or clinical engagement mechanisms?

The department has discussed existing community and clinical engagement structures with state and territory governments and intends to avoid duplication, where possible.

5.3 Will there be any restrictions on the governance and membership of Clinical Councils and Community Advisory Committees?

The department is considering the structure and membership of Clinical Councils and Community Advisory Committees as part of the policy development process. Further information will be included in the Approach to Market documentation.

5.4 Will there be any restrictions on the membership of Primary Health Network Boards?

PHNs will be required to establish skills based Boards as recommended in the Review of Medicare Locals.

6 Approach to Market

6.1 What will the selection process for Primary Health Networks involve?

PHN operators will be selected through a transparent, competitive, open process.

6.2 Who can apply to become a Primary Health Network?

The Approach to Market will be open to public and private organisations.

6.3 When will the selection process for Primary Health Networks take place?

The selection process for PHNs is expected to commence in late 2014.

6.4 Will industry briefings take place following the release of the Approach to Market?

The department will conduct industry briefings shortly after the release of the Approach to Market.

6.5 How can I register to attend an industry briefing?

The department encourages health industry organisations to contact the [PHN inbox](#) to express interest in attending the industry briefings regarding the Approach to Market.

6.6 Will the department provide guidance or assist in the formation of partnerships for the Approach to Market?

The department is not in a position to advise on likely partners or assist in the formation of partnerships for the Approach to Market for PHN operators. The department is mindful of not providing a competitive advantage to any entity or sector in this process and will not enter into discussions with any party around partnership arrangements.

7 Contact

If you have a question that has not been addressed above, please contact the department via the [PHN inbox](#) and your question will be responded to as soon as is possible.

Appendix 7

Review of Medicare Locals – Report to the Minister for Health and Minister for Sport (extract)

Recommendations

- 1: The government should establish organisations tasked to integrate the care of patients across the entire health system in order to improve patient outcomes.
- 2: The government should consider calling these organisations Primary Health Organisations (PHOs).
- 3: The government should reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal.
- 4: The principles for the establishment of PHOs should include:
 - contestable processes for their establishment;
 - strong skills based regional Boards, each advised by a number of Clinical Councils, responsible for developing and monitoring clinical care pathways, and Community Advisory Committees;
 - flexibility of structure to reflect the differing characteristics of regions;
 - engagement with jurisdictions to develop PHO structures most appropriate for each region;
 - broad and meaningful engagement across the health system, including public, private, Indigenous, aged care and NGO sectors; and
 - clear performance expectations.
- 5: PHOs must engage with established local and national clinical bodies.
- 6: Government should not fund a national alliance for PHOs.
- 7: The government should establish a limited number of high performing regional PHOs whose operational units, comprising pairs of Clinical Councils and Community Advisory Committees, are aligned to LHNs [Local Hospital Networks]. These organisations would replace and enhance the role of Medicare Locals.
- 8: Government should review the current Medicare Locals' after hours programme to determine how it can be effectively administered. The government should also consider how PHOs, once they are fully established, would be best able to administer a range of additional Commonwealth funded programmes.
- 9: PHOs should only provide services where there is demonstrable market failure, significant economies of scale or absence of services.

10: PHO performance indicators should reflect outcomes that are aligned with national priorities and contribute to a broader primary health care data strategy.

Appendix 8

Medicare Locals—examples of services and programs

The following information has been drawn from evidence provided to the committee and Medicare Local websites.

New South Wales

Murrumbidgee Medicare Local¹

- Aboriginal health
- After hours
- Aged care
- Antenatal shared Care
- Professional Development services for health practitioners in the region
- eHealth including developing and maintaining Personally Controlled Electronic Health Records
- Healthy Community Initiative
- Healthy Lifestyle Program
- HealthPathways
- Immunisation
- Integrated and Coordinated Services
- Integrated Allied Health Services
- Integrated Chronic Disease Program
- Mental Health
- Osteoporosis Fracture Prevention Service
- Otitis Media
- Parkinson's Support Nurse
- Pitstop (Men's health service)
- Smoking cessation
- Refugee health
- Rural Health Outreach Fund
- Town Tracks (health program for rural Australians with low physical activity)

1 www.mml.org.au/about-our-services/programs (accessed 19 November 2014)

- Workforce

North Coast New South Wales Medicare Local²

- North Coast NSW Medicare Local co-ordinate a range of Aboriginal health programs and services across the North Coast:
 - Bulgalwena General Practice
 - Jullums Lismore Aboriginal Medical Service
 - Care Coordination and Supplementary Services (CCSS)
 - Closing the Gap
- After Hours Primary Care to incentivise and support GPs providing after hours services.
- Continuing Professional Development by supporting professional development for a range of primary health providers.
- Copernican Inversion Services (a breakfast meeting showcase of the health care community).
- eHealth including developing and maintaining Personally Controlled Electronic Health Records.
- Healthy North Coast: an online hub to provide health advice to the North Coast region (including exercise and nutrition).
- Supporting immunisation providers on the North Coast.
- PITCH (Practical Ideas to Change Healthcare) – innovation and creativity in health services.
- Wrapped around Support for Practitioners and Providers (supporting greater co-ordination and integration of primary health care services).
- Aboriginal Health Services.
- Headspace Lismore.
- Mid North Coast Specialist Outreach Clinic.
- NewAccess (personal coaching).
- Nimbin Medical Centre.
- Northern Rivers Family Care Centre.
- Tarmons House Mental Health Service (Lismore).
- Winsome Health Clinic.

2 Mr Saberi, North Coast Medicare local, Committee Hansard, 15 September 2014, p. 26; and www.ncml.org.au/index.php/programs-services (accessed 19 November 2014).

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- North Coast Allied Health Association – a single organisation for allied health professionals in North Coastal area of NSW
 - Regional Aboriginal health plan
 - Regional Mental health plan
 - Regional Aged care Plan
 - Palliative care services

Southern New South Wales Medicare Local³

- Aboriginal health services including:
 - Koori health checks (free health checks in a local general practice)
 - Koori Diabetes Days (free diabetes monitoring and treatment)
 - Koori Boois (Mums and bubs clinic and playgroup)
 - School clinic visits (clinic style health check services for Aboriginal school students)
 - Butt out Boondah (tobacco cessation and support)
 - Deadly Dads (promotion of fatherhood and grandfatherhood)
 - Living strong (healthy lifestyle programs)
 - Coordinated Care and Supplementary Services (chronic medical condition management)
- Mental Health programs, including
 - Cool Kids (10 week school based childhood anxiety program)
 - Chilled (high school anxiety program)
 - Study without stress (Year 12 stress management)
 - Mental Health First Aid (support for patients developing mental illness)
 - Be There Suicide Prevention Gatekeeper Training (competency based suicide prevention training course)
- HealthPathways
- Southern New South Wales Partners in Recovery (mental health treatment and community based support)
- Youth health services, including
 - General youth health
 - Alcohol and drugs

3 www.snswml.com.au/our-health-programs.html (accessed 19 November 2014).

- Cancer screening and treatment
- Healthy eating and physical activity
- Mental health
- Safety (driving, partying, bullying and online) and violence
- Sexual health
- Sexuality
- Smoking
- Young carers
- HEAL, a program for overweight, not physically active or at high risk of diabetes or cardiovascular
- Foot care services in Eurobodalla and Yass
- Population health services

Queensland

Central Queensland Medicare Local⁴

- Aboriginal and Torres Strait Islander Health
- Accreditation of health services
- After Hours Care services
- Cardiovascular disease advice and management
- Chronic condition management
- Diabetes management
- eHealth including developing and maintaining Personally Controlled Electronic Health Records
- Healthy living program
- Immunisation
- Mental health
- Palliative care
- Patient opinion and feedback
- Physical activity
- Practice management
- Preventative health
- Refugee health

4 www.cqmedicarelocal.com/#!resources/cfvg (accessed 19 November 2014).

-
- Respiratory disease
 - Telehealth services
 - Women's and children's health

South Australia

Central Adelaide and Hills Medicare Local⁵

- After Hours Care grants, incentives and projects including the Adelaide Hills Aged Care After Hours Project and the Community Awareness Raising Project targeting culturally and linguistically diverse communities;
- Aged Care programs including improved inter-agency collaboration and service integration and in falls prevention, medication management, and oral health;
- Australian Primary Care Collaboratives Program (Quality Improvement Program) which is providing independent accreditation standard for GPs;
- coordinating Closing the Gap (Indigenous Health) services and activities including the care coordination program;
- coordinating a quality improvement project that focussed on improving outcomes for patients with Chronic Obstructive Pulmonary Disease,
- programs to improve childhood immunisation rates
- a number of Mental Health programs including Access to Allied Psychological Services, Partners in Recovery, Beyond Blue New Access (an early intervention telephone counselling service for mental health), and headspace.

Country North South Australia Medicare Local⁶

- After hours
- Aboriginal health (and Closing the Gap)
- eHealth, including developing and maintaining Personally Controlled Electronic Health Records
- Mental health
- Partners in Recovery

5 Central Adelaide and Hills Medicare Local, *Overview of programs*, <http://cahml.org.au/overview-of-programs.html>, (accessed 19 November 2014); and Mr Chris Seiboth, CEO, Central Adelaide and Hills Medicare Local, *Committee Hansard*, 9 October 2014, pp 14–15.

6 www.cnorthhealth.com.au/ (accessed 19 November 2014).

*North Adelaide Medicare Local*⁷

- Aboriginal health
- Chronic disease projects
- Mental health
- After hours
- Nursing and Immunisation
- eHealth, including developing and maintaining Personally Controlled Electronic Health Records
- Largest provider of clinical mental health services in the region – where there are few private providers and high disadvantage
- 11 mental health programs providing clinical therapeutic interventions, individual and group across the age range and diagnostic criteria – delivered over 24000 occasions of service this year
- high quality and efficient services in Mental Health and Aboriginal Health
- build health literacy, promotion, early intervention and client empowerment into every program delivered
- services under Closing the Gap to ensure that Aboriginal and Torres Strait Islander peoples can exercise choice, care coordination, empowerment and self-management
- ensure that General Practice has access to assistance in providing culturally appropriate services – providing 5 sessions of cultural awareness training to our service providers
- implemented a new model of After Hours Incentive funding –with 100% uptake from General Practice

*Tasmania**Tasmanian Medicare Local*⁸

- services to patients with complex chronic conditions (HealthPathways program); and streamlined discharged care program, which looks at streamlined processes for discharge, to prevent avoidable readmissions and ensure avoidable admissions initially;

7 www.naml.com.au/programs-services (accessed 19 November 2014); further information about the services NAML currently provides and which could be lost in the transition to PHNs, see *submission 93* from the NAML.

8 Dr Judith Watson, Chair, and Mr Phil Edmondson, CEO, Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, pp 2–10.

-
- successful exercise treatment initiative, which is aimed at improving community management of chronic disease;
 - TML is partnering NGOs to address smoking rates across the whole Tasmanian population;
 - a program to minimise the harmful alcohol and drug use amongst young Tasmanians through a partnership with one of the local youth agencies in Tasmania and through Headspace;
 - access to fresh fruit and food and with healthy eating at the community level;
 - partner agency in Partners in Recovery mental health program;
 - involvement in the mental health nursing initiative;
 - access to Allied Psychological Services mental health program on a statewide basis;
 - services for the Indigenous community in the mental health space;
 - medical services for refugees; and
 - work to improve health literacy at the service provider level;
 - funding GPs for the comprehensive delivery and support for delivery of community accessible after hours care;
 - GP Assist program which supports rural GPs to avoid the impost of 24-hour, seven-day-a-week after-hours care requirement;
 - collaboration with the university's establishment and embedding of the virtual Tasmanian Academic Health Science Precinct approach to reform of the health services research sector;
 - working with the Human Interface Technology Laboratory at the University of Tasmania to make better use of high-end technology to have work happen in patients' own homes in partnership with them.

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Victoria

Barwon Medicare Local⁹

- Aboriginal health services, including:
 - Closing the Gap
 - Indigenous Chronic Disease (providing support to the health sector and better access to health care by Indigenous Australians)
 - Indigenous PIP (a gateway service to which patients can access services through the Closing the Gap program)

9 www.barwonml.com.au/health-professionals/clinical-services-support (accessed 19 November 2014).

- Advance Care Planning (future treatment options and Advance Care Plan making)
- After Hours care
- Aged Care
- Allied health networks
- Cancer and Palliative Care Programs
- Collaborative programs (a system of improving health care through shared learning, peer support, training, education and support systems.)
- Diabetes managements program
- Docs and Teens (youth access to health services)
- Immunisation services
- Life scripts
- Medicare information and support programs
- Mental health
- Paediatric health

Bayside Medicare Local¹⁰

- Aboriginal health
- After hours
- Aged care
- Chronic disease management
- Clinical services
- eHealth including developing and maintaining Personally Controlled Electronic Health Records
- Family and child health
- Family violence
- Mental health

Loddon Mallee Murray Medicare Local¹¹

- Aboriginal health and Closing the Gap
- After hours

10 <http://bml.org.au/> (accessed 19 November 2014)

11 http://www.lowermurrayml.com.au/#!c_services/clger (accessed 19 November 2014)

-
- Allied Health
 - Autism and developmental disorders
 - eHealth, including developing and maintaining Personally Controlled Electronic Health Records
 - Immunisation programs
 - Mental Health
 - Movement disorders
 - Otitis Media

Western Australia

Perth South Coastal Medicare Local¹²

- the procurement of after-hour services, which have been brought to the southern parts of the Medicare Local for the first time;
- strong chronic disease programs;
- strong mental health programs;
- programs for low socio-economic groups available at no- or low-gap cost to members of the community;
- diabetes education scholarship program, which pays course fees at Curtin University for diabetes educators who are working as practice nurses in a local practice; and
- services across mental health, Aboriginal health, after-hours general practice and chronic conditions.

Goldfields-Midwest Medicare Local¹³

- securing dietitians, diabetic educators, physiotherapists and other various allied health services to communities who previously did not have access to these services;
- improving after-hours services in both major regional towns of Geraldton and Kalgoorlie.
- improving the health and wellbeing of older persons in the community, or living in residential aged care facilities;
- the Butt Out–Living without Smoking Program;

12 Mr Paul Hersey, CEO, South Coast Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 11–17.

13 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, pp 10–15.

- the Closing the Gap (CTG) program which provides on the ground support to clients and assistance to GPs and allied health services to reduce barriers to health care;
- improving access to dietetic and diabetes education services for people residing in rural and remote settings;
- the Immunisation program aims to increase immunisation rates;
- the Partners In Recovery program provides coordinated support and flexible funding for people with severe and persistent mental illness with complex needs;
- the Take Heart Cardiac Rehabilitation program which provides support for people who are recovering from a cardiac condition, or those at significant risk of cardiovascular disease;
- encouraging further use of Telehealth for specialists, general practices, residential aged care facilities or Aboriginal medical services and increase the delivery of health services across the region.