Australian Council of Social Service

Submission to the National Health and Hospitals Reform Commission

Response to Interim Report: A healthier future for all Australians

ACOSS, March 2009

Introduction

ACOSS commends the Commission on its Interim Report, *A Healthier Future for all Australians*, and particularly welcomes the Report's strong focus on:

- recognising the importance of additional targeted assistance to groups whose health outcomes are worse than others, within the context of a universal health system
- closing the health gap between Indigenous and non-Indigenous Australians
- redressing the inequalities in oral health and access to dental care
- promoting health and preventing illness
- placing health consumers and comprehensive primary care at the centre of the health system.

This submission focuses on the financing and governance sections of the Interim Report as the drivers of integrated systemic reform and touches briefly on oral health and aged care where the Commission has flagged new reform directions and in which ACOSS has a particular interest.

Financing

ACOSS commends the Commission for its strong opening statement on the importance of a universal health system.

Perhaps the first consideration when thinking about the financing of the health system is what should be universally covered and what should be available through private payment.

The Interim Report does not directly address this question but asserts that Australia's mix of public and private financing is generally regarded as one of the strengths of our health system and that the Commission wants to see the overall balance of spending through taxation, private health insurance and individual's out-of-pocket contributions maintained. At the same time, the Commission recognises that there are concerns about the costs borne by individuals for some health services, such as dental care and aids and appliances. It is no coincidence that in the areas where there is not effective universal provision that the deepest divides in health status and access to services are observed.

Any long term plan for the health system must deal directly with the role of public funding, private health insurance and patient co-payments. The Commission has touched on a possible expanded role for private health insurers in relation to the Denticare proposal and Option C under the Governance proposals, where private health funds may evolve into the providers of comprehensive health plans and purchasers of health care, in a competitive market.

The core question is whether private health insurance should play a central role in the health system or a residual role where people privately ensure in a competitive market for services that are not universally covered.

Setting priorities

It is clear that no system of health, aged and disability services can provide everything to everyone and, in this regard, systems differ internationally only in terms of how explicit the choices are about what is provided to whom and on what terms. This is so in even apparently open-ended, universal, entitlement-driven programs because all services rely on

actual resources (people in the form of attendant care workers, nurses, doctors, pharmacists and so on) which are in finite supply.

Australian governments have not been explicit about these choices, but if we are to move to an expanded and more 'universal' system, then it is crucial that the community debates these choices and decisions are made explicit.

It has been consistently observed that the legitimacy and sustainability of major policy decisions depends on how well they reflect the underlying values of the public. As governments try to deal with difficult choices, policy needs to be informed by ordinary "unorganised" citizens, as well as powerful "organised" interest groups.

We therefore suggest that a renewed Commonwealth/State commitment to a universal system start with a rigorous process for identifying the values and priorities that the public wishes to see reflected in the Australian system.

The World Health Organisation identified a number of useful and realistic principles for thinking about universality:

- Membership is defined to include the entire population. Coverage is compulsory with the population covered inclusively.

- Universal coverage means coverage for all, not coverage of everything. A core benefit package has to be clearly defined taking into account the resources available and the cost of priority interventions. This also requires an assessment of the services and inputs for which individuals are able and willing to pay out of their own pockets, and the political feasibility of various choices. Lower priority services, which will vary from one country to another, will only be available for payment.

- Services may be offered by providers of all types. Ownership status does not matter. A strong purchasing authority which sets standards and enforces a common set of quality and utilisation regulations will enable the most efficient providers of services to flourish, whether private or public.

Public and private funding
Taking the above principles as a starting point, ACOSS supports a more limited role for private health insurance which is focused on providing services that are not available universally or a standard of care that exceeds the acceptable minimum benchmark for universally funded care.

However even if private health insurance has a central role, ACOSS considers that there is no case for continuation of the taxpayer funded Private Health Insurance Rebate and the exemption from the 1% Medicare surcharge for high income earners who hold private health insurance. These are effectively a Government subsidy for the health care choices of the better off and have no place in a fair and sustainable health system. When consideration is given to rebuilding public revenue following economic recovery, we would expect there to be strong pressure on inefficient and ineffective subsidies and tax breaks such as these.

ACOSS therefore recommends that any long term health plan embed the removal of the 1% reduction in the Medicare Levy for high income earners who hold private health insurance and the phased removal of the Private Health Insurance Rebate, with the funds then shifted into expanding universality.

To the extent that universal provision needs to be expanded and where efficiency and effectiveness gains are not sufficient to cover these additional costs – for example if primary dental care were to be universally covered – then these costs should be met through general taxation and/or an increase in the Medicare Levy, as proposed by the Commission in relation to its 'Denticare' proposal.

User contributions
As the Interim report states, direct user contributions to health funding is a significant feature of the Australian system, with a contribution equivalent to 20% of total funding.

ACOSS has generally opposed the use of direct user contributions to the funding of services because co-payments are generally insensitive to the unequal distribution of wealth and income and the unequal distribution of the need for health and disability care in the community.

Such arrangements can therefore discourage people, especially those least able to afford the payments, from seeking desirable services or make the cost of using those services so burdensome as to deprive people of other necessary consumption, e.g. food and heating.

User payments also add considerably to the administrative costs of programs since there is a cost associated with their collection.

Over time however, user payments have become widespread across the health and community services systems in Australia and ACOSS has been prepared to support the use of co-payments under certain conditions.

Some co-payment schemes, for example, attempt to take into account the differentials in capacity to pay among consumer groups, and/or have safeguards in place to help ensure that no one is denied access to a service because of incapacity to pay. Perhaps the best developed of these are the co-payments for pharmaceuticals and for aged care, although there are a number of problems with the way these both currently work.

The traditional arguments in favour of consumer co-payments are:

- They help ration the use of services.
- They help consumers to value the service they use.
- They provide additional resources for needed services.
- They change the relationship between the service provider and the consumer. The consumer is no longer the recipient of a 'free' service, given by the service provider, but is a customer exercising a degree of market control.
- They reflect community attitudes about self-reliance and self-provision.

Most co-payments however have been introduced or modified on an ad hoc basis for the simple expediency of curtailing government expenditure. Co-payments have not generally been designed to achieve more efficient allocation of scarce resources or to give effect to

sound policy principles. Reflecting this reality is the lack of research into the impact of co-payments on service users, especially low income people, across health, ageing and disability services.

However, there are areas where user payments/contributions are defensible and appropriate.

- Where the service is not agreed to be an essential priority. For example, people should only be able to access things like the doctor of their choice in hospital or deluxe hospital accommodation through private payment, un-subsidised by public funding.

- Where there is a less expensive but equally effective alternative. For example, people should have to pay the excess for choosing a more expensive brand name pharmaceutical over a cheaper but equally effective generic pharmaceutical.

- Where a user contribution is the most equitable and acceptable alternative to other methods of funding the service. For example, there appears to be greater community support for means and asset tested accommodation bonds for residential aged care than there is for inheritance taxes which could also be used to co-fund residential aged care.

If the community agrees that there is a case for co-payments this should be done in such a way as to ensure that:

- the level of contribution is proportional to capacity to pay
- there is no payment required at the time the person enters or uses a service so as not to dissuade someone from using a needed service when it is needed
- the level of co-payment is regulated and capped
- there are annual and lifetime ceilings for heavy users of services and safety nets operate on the basis of the consumer's total outlay, not as outlays under different programs.

Under such a scenario, co-payments could be collected by the Commonwealth through the tax system and then returned to the States under the block funding arrangements discussed below.

Services would keep records of the people who use their services (as is the case now) but would not be permitted to charge people at the point of service. These records would be provided to the Commonwealth (as is the case now for Medicare and Child Care payments) for each individual's contribution to be calculated according to means and relevant co-payment scales, thresholds and limits. The co-payment would then be collected at the time a person pays his or her tax. This arrangement would allow a much finer gradation of co-payments according to means. It would also avoid the problem of people not seeking services because they did not have cash on hand at the time they needed the service. (The Commonwealth is in the best position to administer user contributions as it has responsibility for incomes, tax and social security payments and has the administrative systems and experience to determine the scales, thresholds and limits of co-payments across the major health and community services covered by this paper.)

Governance

As the Interim Report recognises, the governance arrangements for health care have been the single most controversial issue the Commission has been asked to tackle. The three governance options presented in the report are not the only plausible options to consider.

Building on the existing functions of Commonwealth and State and Territory governments makes good sense.

State and Territory Governments have responsibilities for the planning, budgeting and administration of health and community services, with the major exceptions being private medical services, community pharmacy, aged care and private allied health and complementary therapy services. State and Territory responsibility for human service planning and administration complement their responsibilities for land use planning, housing, transport and the provision of basic infrastructure such as electricity, gas, water and sewerage.

The Commonwealth on the other hand is the major funder of services because of its broad taxation powers, with around 70% of all funding for health, aged and disability services ultimately coming from the Commonwealth. This gives the Commonwealth effective control over national policy settings.

Sensible solutions to the jurisdictional issues confronting the health and related aged and disability care systems will need to be embedded in Australia's existing federal framework.

In ACOSS' view this suggests that the Commonwealth should be responsible for setting, with the States and Territories, the parameters for a national health system, while allowing State and Territory Governments flexibility in how they deliver on this.

Integrated, systemic reform is needed as reform to just some elements of the health and community services system is likely to create more challenges than solutions.

Any major change to the structure of joint funding arrangements in any one area (aged care, mental health, disability etc) would need to take account of the impact on local communities where Commonwealth, State and Territory health and community services all operate together.

Many of the interface problems in the health system occur between:

- Commonwealth-funded primary care (i.e. MBS funded general practitioner services) and state funded primary and community care services (e.g. community health care centres, maternal and early childhood centres, community mental health services and home and community care services).
- State-funded public hospitals and Commonwealth funded primary care (ie GPs) where it is crucial integration occurs to avoid hospitalisation through accessible and effective primary health care or to provide seamless step down care when a person leaves hospital.
- Commonwealth funded private hospitals and state funded public hospitals.
- Pharmaceuticals provided through hospital pharmacies and pharmaceuticals provided through community pharmacies.

Whichever governance option is ultimately adopted it certainly makes no sense for one level of government to run acute care and the other to run primary care. Nor does it make sense for one level of government to run the health and aged care system while another runs disability services. Aged care, whether in residential or community settings, should be seen as part of a service continuum which provides assistance to people with disability, according to their level of need.

ACOSS would therefore support an option which delivered to either the Commonwealth or the States and Territories overall responsibility for the planning, budgeting and administering of health, aged and disability services.

We would encourage the Commission to consider, or reconsider, governance options which:

- Clarify the Commonwealth's role as the major funder of services and its responsibilities for developing agreed national policy directions, establishing independent monitoring of performance against agreed minimum outputs and outcomes and creating incentives for states to lift standards across the health, aged and disability care systems.

- Expand State/Territory Government responsibility for planning, budgeting and administering health and community services by transferring responsibilities which are currently Commonwealth responsibilities to the States (e.g. aged care, private medical care and community pharmacy.) Under this scenario, States/Territories would be responsible for commissioning the full range of health services which are to be universally covered and the regional allocation of health funding and services to meet agreed population health outcomes, access benchmarks and service quality.

Under such an option the total funding pool would be funded jointly by the Commonwealth and the States (nominally split 70% Commonwealth and 30% State) on a weighted capitation basis. That is, the level of funding would match a set dollar amount determined by a per person calculation to deliver health, aged and disability services to everyone in the community according to need, adjusted for the demographics (including level of regionalisation / remoteness) of each State and Territory.

Capitation would create the necessary incentives to drive system reform and ensure resources are allocated most efficiently to achieve agreed outcomes. It can be expected to drive investment in prevention and early intervention policies and programs. However, there should be some flexibility to allow budget over-runs with the consequence being a review of performance rather than penalties (which would disadvantage service users).

The Commonwealth would retain responsibility for negotiating the price of pharmaceuticals on the basis of cost-effectiveness and for the financing arrangements of the Pharmaceutical Benefits Scheme, including the setting and collection of co-payments which would then be returned to the States as part of block funding arrangements, if it is decided that there is a continuing role for co-payments.

Similarly, the Commonwealth would retain primary responsibility for the tertiary training of health professionals, professional registration, health research, and the monitoring of the safety, effectiveness and cost-effectiveness of new medical technologies and procedures. As the primary funder of the health system, the Commonwealth needs to ensure that new and existing medical procedures attracting funding are supported by evidence of their safety, clinical effectiveness and cost-effectiveness.

Such an option would provide the States and Territories with the incentives and capacity to integrate and develop services for the benefit of service users. For example, States and Territories would have the capacity to innovate across the relevant service spectrum from medical and hospital services to care in the home, aged and disability care, and patient transport – allocating resources to fit best with the needs of service users and in the most efficient manner.

Funding arrangements between the Commonwealth and the States should require progressive realisation of equitable access to services across the country. This would mean, for example, State and Territory Governments using resources flexibly and creatively so that in areas where the supply of services is difficult or impossible to provide, resources are used to improve transport linkages and accommodation options where people have to travel to access needed services.

Once agreements are in place, the centre of the health system would be a revitalised network of integrated primary health, aged and community care services that bring together local GPs, community health and aged and disability care in effective local partnerships. Each community health service would be made responsible for working in partnership with GPs, non-government organisations and other state government departments in meeting the health and care needs of a geographically defined catchment population within the context of national policies.

Together with population health services, these services will form the first tier of a transformed health system. Once in place, these first tier services would become the first point of contact for all but the most critically ill. As secondary and tertiary providers, the role of public hospitals is to back up and support a first tier network of GPs and community health.

A critical feature of each primary health and community care service will be a formal health and community care partnership that makes provision for workforce flexibility and shared infrastructure to support extended service networks including IT and referral systems, tele-health, training, transport and workforce development.

Oral Health

The Commission has clearly identified the inequalities in oral health and access to oral health care in Australia. The Interim Report's 'Denticare' proposal is a major reform idea.

The way in which the provision of more equitable oral health care is structured depends on the structure of the overall health system but whatever options are pursued, the first priority must be the development of primary dental/oral health programs targeting low income adults and children with the worst oral health.

Over time, ACOSS would prefer a model where primary oral health care is included as part of a comprehensive approach to primary health care – universally covered and part of the package of services that States/Territories would be responsible for phasing in over time under a national health plan.

More complex and costly procedures should also be covered universally and rationed according to clinical need. Such procedures are currently covered in the public system but are severely rationed and policies are needed to significantly expand access to these procedures.

Private insurance would be available to those who wanted to insure for procedures not covered universally or for a standard of care that exceeds the acceptable minimum benchmark for universally funded care.

Aged and disability care

The Commission has suggested some very significant reform directions in aged care, including a change to the way in which aged care subsidies are calculated, a relaxation of the regulations governing aged care to enable greater consumer choice, and placing the aged care component of the Home and Community Care Program (HACC) under the direct control of the Commonwealth.

In keeping with the general approach of this submission, ACOSS believes that medical and disability care (including assistance with personal care, cooking and cleaning where needed) should be provided universally – whether delivered in hospital, residential care facility, in the community or at home. Services above and beyond those which are covered universally would only be available through private payment.

On the other hand accommodation costs and general living expenses should be met by the individual according to means (including through accommodation bonds for high level residential care where appropriate) along with means tested government assistance.

Whether funding follows the individual or the place, the system needs to be planned according to the age and disability profile of the population and built to ensure equitable access according to need (linking the benchmark for residential care to the population of people over the age of 85 seems too narrow). This means careful consideration of the workforce and capital infrastructure needs necessary for a responsive system.

As outlined above, ACOSS has serious concerns about the splitting of the aged and disability components of HACC.