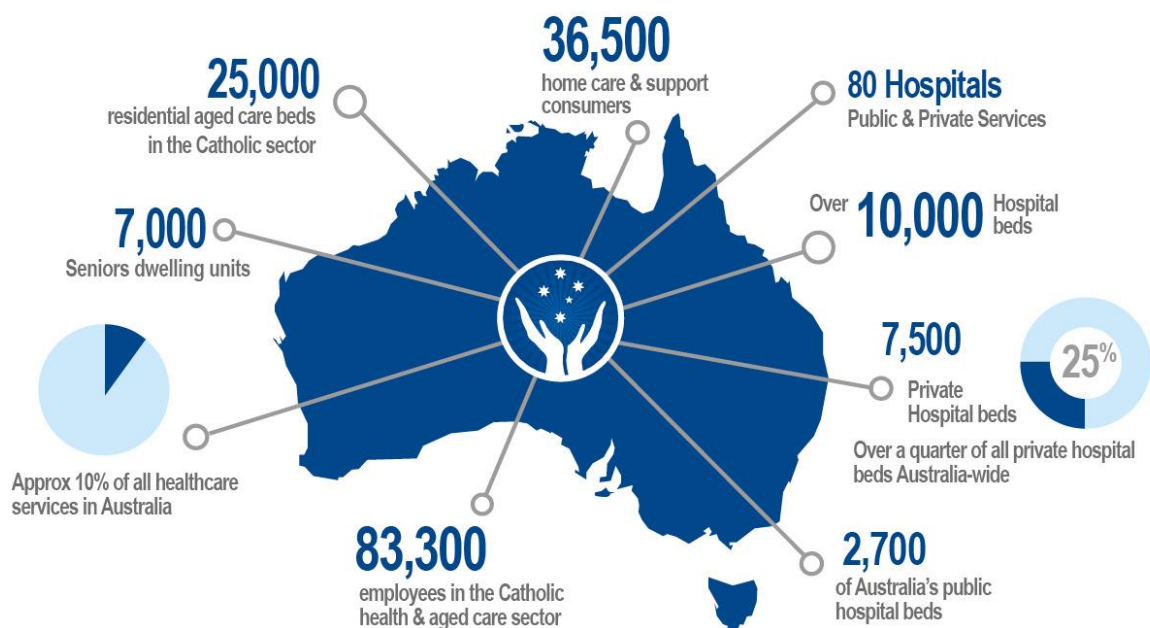


Catholic Health Australia's Health Pre-Budget Submission 2019-20

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10 per cent of hospital-based healthcare in Australia. Our members also provide around 30 per cent of private hospital care, 5 per cent of public hospital care, 12 per cent of aged care facilities, and 20 per cent of home care and support for the elderly.



Australia has one of the best health systems in the world, repeatedly ranking in the top ten worldwide. The Commonwealth Fund, an independent United States (US) think tank, released a report in July 2017 that ranked Australia's health system second overall when compared with 11 other high income

countries.¹ Australia ranked number one when it came to health outcomes, demonstrating the high quality care our system is able to provide.

However, in the same study, the 11 countries' systems were tested through a number of categories including care process, access to healthcare, administrative efficiency, equity, and healthcare outcomes.

While Australia did come in second overall, the Australian system is by no means perfect. Australia ranked 7th in the equity category, which looks at the difference in healthcare available to high income and low-income earners, and 4th in the access category which focused on affordability and timeliness. These were the two lowest rankings of our system.

In this pre-budget submission, CHA have focused on four policy areas where we believe that access and equity to healthcare still requires better funding and policy reform to meet the unmet health demands of all Australians.

These areas are:

- better funding and resourcing of palliative care,
- reducing inequalities for regional, rural and remote Australians,
- better transparency of out-of-pocket fees and,
- ensure all patients enjoy access to timely medical treatments in public hospitals regardless of their insurance status.

CHA welcomes any requests for further information pertaining to this submission.

Please contact:

Suzanne Greenwood, Chief Executive Officer, Catholic Health Australia.

suzanneg@cha.org.au

Policy Area	Government Action Required
Funding and resourcing of palliative care (PC).	<ul style="list-style-type: none">- Establish a National Palliative Care Alliance (NPCA) [estimated cost \$500,000] to act as an expert independent advisory group to the Australian Government on issues relating to PC.- Address systemic funding and access issues.- Strengthen community-based PC to increase at-home death rates and reduce hospitalisations.- Build the capacity of the health and aged care workforce to recognise and respond to PC needs.

¹ Eric Schneider, Dana Sarnak, David Squires, Arnav and Michelle Doty, 'The Commonwealth Fund, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for better U. S. Health Care* (2017), <<http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/>>

	<ul style="list-style-type: none"> - Establish a national minimum data set for PC data collection and continue to work on validated indicators to assess improvement in PC delivery locally and nationally. - Invest in drivers of innovation. - Initiate the conversation to improve PC awareness.
Reducing inequalities in access and health outcomes for regional, rural and remote Australians.	<ul style="list-style-type: none"> - Development of a rural workforce strategy that expands further training opportunities for medical students in regional and rural private hospitals. - Include health services in future infrastructure grant opportunities for regional and rural hospitals to deliver technological improvements that can be more costly than for metropolitan services. - Improve the value proposition of PHI in regional and rural areas with strategies that mitigate the growing numbers of PHI policies with exclusions and restrictions and the associated increases in OOP costs. - Include Regional Hospitals as a distinct topic in any future reviews of the private health sector. - Work with state and territory governments to improve partnership opportunities between public and private facilities and reward providers where the relationships are operating efficiently.
Transparency of out-of-pocket fees.	<ul style="list-style-type: none"> - Conduct a comprehensive review from the consumer perspective with modelling that outlines the real OOP costs associated with healthcare facing consumers. - Enhance the provision and accessibility of information to consumers to assist with pre-admission choice of doctor and improved understanding of charges that may be incurred in both public and private hospitals. - Prioritise research and funding for new models of maternity care across both public and private systems. - Consultation with ministerial advisory committees and the health sector to ensure any form of price disclosure of medical services is conducted with due diligence.
Private patients in public hospitals	<ul style="list-style-type: none"> - Enforce compliance with the Medicare principles so that private patients do not receive quicker treatment or other preferential treatment to public patients.

	<ul style="list-style-type: none"> - Remove hospitals' ability to offer inducements or actively compel consumers to declare their private health insurance status. - Enhance the provision of information to consumers to assist with pre-admission choices. - Ensure that private patient election forms are submitted to the relevant health fund and that public hospitals provide Hospital Casemix Protocol data to insurers where private health insurance is claimed. - Include provisions for the next public hospital funding agreement between the Commonwealth and states ensure and address the current funding incentives for public hospitals to maximise private patient activity. - Use available capacity within private hospitals more effectively to free up public hospital beds so that public hospitals can provide timely, high quality care to those who need it. Optimise the split of public and private hospital activity so that services are delivered in the most cost-effective and appropriate setting.
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Improve access to quality palliative care (PC)

Key Recommendations

Establish a National Palliative Care Alliance (NPCA) [estimated cost \$500,000] to act as an expert independent advisory group to the Australian Government on issues relating to PC.

- The NPCA should support the Government by providing strategic, evidence-based advice on priorities of national importance, policy and practice implementation and evaluation strategies. The NPCA should report to the Australian Government through the Minister for Health, providing annual reports to the Minister.

Address systemic funding and access issues.

- Review all explicit or implicit time-dependent access requirements to funding (e.g. ACFI) and admittance to inpatient PC facilities.
- Review the Medicare rebate for medical services provided for PC activity. This includes a review of flexibility to provide multidisciplinary holistic care, advanced care planning and remuneration for items such as case conferencing and home visits.
- Ensure ACFI provides adequate funding that aligns with the level of care and skill required to care for those needing PC that goes beyond terminal care. This also

involves improving ACFI agility to respond to episodic needs with supplementary payments.

- Develop recommendations for funders to guide provisions for equipment, medication and services for community-based care.

Strengthen community-based PC to increase at-home death rates and reduce hospitalisations.

- Support intensive 24-hour access to PC support, and not just in hospitals. This includes implementation of 24-hour telephone support, innovative telehealth options for remote monitoring of symptoms, and expansion of PC consultancy services.
- Enabling at home death requires improvements to the resourcing of community PC and integration of services. Organisations with existing capabilities to provide a continuum of care, such as hospitals, should be funded to do so.

Build the capacity of the health and aged care workforce to recognise and respond to PC needs.

- Fund ongoing education programs for the wider health workforce to improve PC literacy.
- Develop capabilities frameworks for PC competencies for aged care staff and health care staff.
- Establish a strategy to address the urgent shortage of trained PC nursing staff together with tertiary education institutions.

Establish a national minimum data set for PC data collection and continue to work on validated indicators to assess improvement in PC delivery locally and nationally.

Invest in drivers of innovation.

- Increase investment in PC research to improve the evidence base using targeted funding opportunities such as the Medical Research Future Fund. Areas of focus should be advised by the NPCA.

Initiate the conversation to improve PC awareness.

- Provide funding to allow specialist PC services and other appropriate organisations to improve end-of-life literacy about PC, end-of-life planning, death and dying.

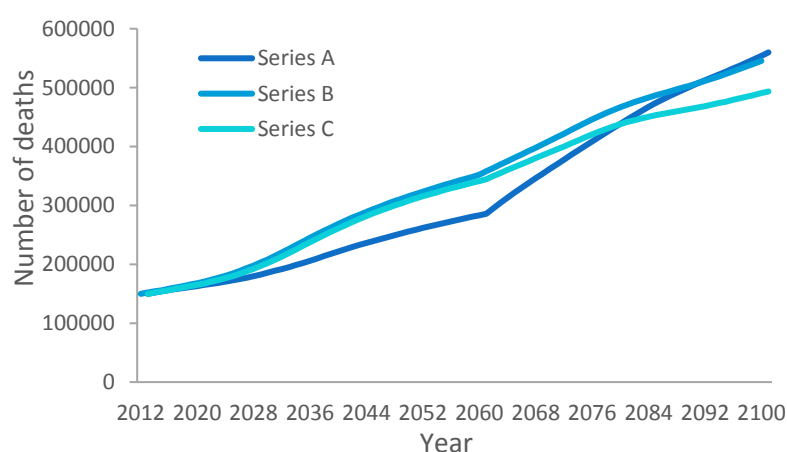
More Australians will need end of life services including palliative care (PC) in the coming years than ever before. Australia has an ageing population and an increasing burden of chronic disease, which ultimately leads to a larger number of deaths per year. Yet PC rarely rates as a political issue on its own merits with the exception of the relationship as an alternative to voluntary assisted dying (VAD). We, as a nation, need to embrace and resource PC as an integral part of health care that affects everyone in society. While not all people who are dying will benefit from PC, there is a large disparity in the number of people who would likely benefit from PC and those

that receive PC. It is estimated that 90 per cent of cancer patients and 50 per cent of non-cancer patients could benefit from PC services, yet only half of those in need actually receive it ^{2 3 4}.

Demand for PC services are predicted to increase dramatically over the coming decades. By 2056, those aged over 65 will increase from 15 per cent to 22 per cent and the proportion of people aged over 85 will double⁵. As a result of the ageing population and high rates of chronic disease, the number of deaths is increasing rapidly and is predicted to more than double by 2061 (Fig. 1) ⁶.

While efforts at all levels of government in Australia are being made to improve end of life care (EOLC), for those delivering service the frustration with systemic barriers inhibiting the care of the dying is palpable. Australia is ranked second in the world for quality and access to PC services, which should be an indicator that our PC system is well resourced and integrated. However, where consistent access to appropriate levels of PC should be given from the time of diagnosis of a life-limiting illness, the reality is that identification of PC needs and referral to PC services is late and treatment is fragmented. There are consistently groups of people who fail to access PC. These include, but are not limited to, the elderly, particularly in terms of access to early PC ⁷, Indigenous Australians ^{8 9} and those living in regional and remote Australia.

Figure 1: Predicted Deaths



Source: ABS 3222.0 - Population Projections, Australia, 2012 (base) to 2101

² Australian Institute of Health and Welfare. Palliative care services in Australia. AIHW; 2018.

³ Palliative Care Australia. Palliative care service provision in Australia: A planning Guide. Canberra; 2003.

⁴ Murtagh F. E., Bausewein C., Verne J., Groeneveld E. I., Kaloki Y. E., Higginson I. J. How many people need palliative care? A study developing and comparing methods for population-based estimates. Palliative medicine. 2014;28(1):49-58.

⁵ Australian Bureau of Statistics. Population projections, Australia, 2012 (base) to 2101. In: ABS, editor. Canberra: ABS; 2013.

⁶ Australian Bureau of Statistics. Population Projections, Australia, 2012 (base) to 2101. Canberra: ABS.

⁷ Burge F. I. A Population-based Study of Age Inequalities in Access to Palliative Care Among Cancer Patients. 2008;46(12):1203-11.

⁸ O'Brien A. P., Bloomer M. J., McGrath P., Clark K., Martin T., Lock M., Pidcock T., van der Riet P., O'Connor M. Considering Aboriginal palliative care models: the challenges for mainstream services. Rural and remote health. 2013;13(2):2339.

⁹ Eastman P., Dalton G. W., Le B. What does state-level inpatient palliative care data tell us about service provision? Journal of Palliative Medicine. 2014;17(6):718-20.

CHA members form a national network of over 77 hospitals, more than 550 aged care facilities and numerous community care organisations. CHA members provide 13 per cent of all PC-related hospitalisations in Australia. In the private sector, CHA members make up the majority of PC inpatient provision and have more than 73 per cent of private inpatient beds. CHA member tertiary services also outperform other services in many of the measured patient outcomes.

CHA members also provide community-based PC services in both the public and private sectors and are among the first organisations to provide private health insurance funded PC in the community setting. CHA community PC services face similar challenges to non-CHA services in achieving patient outcomes, constrained heavily by resourcing.

There are many innovative PC programs operating across Australia aimed at meeting local population needs, improving equity of access, enabling at home death and improving the knowledge-base of PC service delivery. Systemic barriers to continued improvements in PC including remuneration levels, funding models, fragmentation, workforce shortages and lack of awareness of PC limit the longevity of innovative programs and access to PC in general.

The barriers and enablers to PC have been well described by a number of organisations^{10 11}, most recently by the Productivity Commission's Report into Human Services¹². Those barriers include:

- remuneration levels or funding models that act as a disincentive to service
- inadequate data and understanding of population need at regional or national level
- fragmentation of services
- weaknesses in current stewardship arrangements between state and territory governments and the Commonwealth
- lack of awareness in health care workers, particularly in the aged care and primary sector
- public awareness and perceptions of PC
- demand that outstrips supply of services
- lack of research investment
- poor uptake in Advanced Care Planning.

There are evidence-based societal and economic arguments for improving PC in Australia. PC is effective in relieving symptom burden, improving quality of life for those involved and even prolongs survival in some instances^{13 14}:

¹⁰ Health The Department of. Final report: research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice. Canberra; 2017.

¹¹ Johnson C., Girgis A., Paul C., Currow D. C., Adams J., Aranda S. Australian palliative care providers' perceptions and experiences of the barriers and facilitators to palliative care provision. Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer. 2011;19(3):343-51.

¹² Commission Productivity. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Canberra; 2017. Report No.: 85.

¹³ Spilsbury K., Rosenwax L., Arendts G., Semmens J. B. The impact of community-based palliative care on acute hospital use in the last year of life is modified by time to death, age and underlying cause of death. A population-based retrospective cohort study. PLoS One. 2017;12(9):e0185275.

¹⁴ Haines I. E. Managing patients with advanced cancer: the benefits of early referral for palliative care. The Medical journal of Australia. 2011;194(3):107-8.

- More than 85 per cent of PC patients have no severe symptoms by the time they die¹⁵.
- Each dollar invested in extending home-based PC services in NSW would free up \$1.44 of expenditure on inpatient beds¹⁶.
- PC can also support people to die in their setting of preference. In Australia, an estimated 54 per cent of people die in hospitals and only 14 per cent die at home¹⁷, when 50 to 70 per cent of people prefer to die at home^{18 19}.

¹⁵ Palliative Care Outcomes Collaboration. Patient Outcomes in Palliative Care: National Report July-Dec 2017. Australian Health Services Research Institute (AHSRI), the University of Wollongong; 2018.

¹⁶ Silver Chain Group. Submission to the Productivity Commission's Issues Paper. Human Services: Identifying Sectors for Reform. 2016.

¹⁷ Commission Productivity. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Canberra; 2017. Report No.: 85.

¹⁸ Foreman L. M., Hunt R. W., Luke C. G., Roder D. M. Factors predictive of preferred place of death in the general population of South Australia. Palliative medicine. 2006;20(4):447-53.

¹⁹ Ireland A. W. Access to palliative care services during a terminal hospital episode reduces intervention rates and hospital costs: a database study of 19 707 elderly patients dying in hospital, 2011-2015. Internal medicine journal. 2017;47(5):549-556.

Reducing inequalities in access and health outcomes for regional, rural and remote Australians.

Key Recommendations

- *Development of a rural workforce strategy that expand further training opportunities for medical students to regional and rural private hospitals.*
- *Include health services in future infrastructure grant opportunities for regional and rural hospitals to deliver technological improvements that can be more costly than for metropolitan services.*
- *Improve the value proposition of PHI in regional and rural areas with strategies that mitigate the growing numbers of PHI policies with exclusions and restrictions and the associated increases in OOP costs.*
- *Include Regional Hospitals as a distinct topic in any future reviews of the private health sector.*
- *Work with state and territory governments to improve partnership opportunities between public and private facilities and reward operators where the relationships are operating efficiently.*

Around 7 million people, or 29 per cent of the Australian population, live in regional, rural, and remote areas.²⁰ People living in these areas face higher burden of disease and injury, live shorter lives, and have poorer access to health services compared to those living in metropolitan areas. 54 per cent of people living in rural and remote area suffer from one or more chronic diseases compared with 48 per cent in major cities. 69 per cent of people living in outer regional or remote areas are overweight and obese and 1 in 5 smoke daily. The mortality rate for people in remote and very remote areas are 1.3 times higher than those living in metropolitan areas.²¹ Improving equity and access to medical services for the millions of Australian residents living outside of metropolitan areas is vital to improving these health disparities.

A central tenet to the universality of Medicare is timely and accessible medical care for all, but geographic distance from medical services poses a significant barrier to regional and rural patient access to primary services. The AIHW reports from a 2016 survey of health care that 20 per cent of people living in remote and very remote areas reported that not having a GP nearby was a barrier to seeing one compared with 3 per cent of people living in major cities.²² 21 per cent living in outer regional, remote and very remote areas waited longer than they felt was acceptable to get an appointment with a GP compared with 18 per cent in major cities, and 33 per cent reported they could not see their preferred GP on one or more occasions compared with 25 per cent in major cities.²³ 58 per cent of people in remote and very remote areas reported that not having a

²⁰ Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.

²¹ AIHW (2017), 'Rural and remote Australians' retrieved <https://www.aihw.gov.au/reports-data/population-groups/rural-remote-australians/overview>

²² AIHW (Australian Institute of Health and Welfare) 2017. [Rural & remote health](#) (web report). Canberra: AIHW

²³ Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.

specialist nearby was a barrier to seeing one compared to 6 per cent in major cities.²⁴ Limited access to primary services can hinder prevention and chronic disease management strategies that lead to less optimal health outcomes and a need for more intensive tertiary medical care.

The ratio of medical practitioners to individuals indicate a mal-distribution of medical workforce that disadvantages regional and rural communities. Data from 2011 shows that 85 per cent of specialists work in major cities, comprising a ratio of 144.4 per 100,000 people. The ratio of specialists working in regional areas is approximately half of this, with 61.1 specialists per 100,000 of the population. This ratio of specialists to residents is even smaller in remote areas, with 15.5 per 100,000.²⁵ This indicates people living in rural and remote areas are at a significant disadvantage when accessing medical care. With little competition in the market, anecdotal evidence suggests that specialists in these areas are able to charge higher fees. Patients in these regional and rural areas may find they are paying higher OOP costs than their metropolitan counterparts. This also puts increased pressure on the public system in these areas with evidence showing people in outer regional, rural, and remote areas were more likely to have visited a hospital emergency department in the past 12 months than those living in inner regional areas and major cities.²⁶

It also places further financial burden on the Government. Low-income earners who live in areas where bulk billing general practices are less prevalent and therefore subject to OOP charges will ultimately rely on the safety net, leading to increased government spending in welfare payments.

The cost of doing business in regional areas is significantly higher than urban areas. Shipping, transport, financial incentives for professional staff, and patient demographics often make the cost of doing business in regional and rural areas much higher but does not attract additional financial assistance. Approximately 55-70 per cent of CHA hospital costs are workforce related (depending on the case-mix) which is higher than the average cost of urban providers, approximately 50 per cent. Workforce costs are increasing at well over the CPI with nursing wages accounting for a large proportion of the increased hospitals costs.

Many of regional not-for-profit and private hospitals were established in the regions to complement the needs of the public hospitals with some even being co-located. Unfortunately, these relationships have not always evolved in the ways they were intended and in some jurisdictions, workforce arrangements can no longer be shared across the public and private hospitals, creating regional inefficiencies. Public hospitals continue to be incentivised to attract private patients in order to complement their revenue streams.

CHA regional hospitals are extremely well regarded in our community. Medibank have recently published that 98-100 per cent of patients are likely to recommend and 9 out of 10 rated their overall experience highly.²⁷ Private hospitals deliver a great range of economic benefits to regional areas. Health is the largest employer in regional areas, and are a major driver of economic development by bringing in professional staff and infrastructure. Private services give

²⁴ AIHW (Australian Institute of Health and Welfare) 2017. [Rural & remote health](#) (web report). Canberra: AIHW

²⁵ Australian Bureau of Statistics (ABS), "Doctors and Nurses" 4102.0 - Australian Social Trends, April 2013, Canberra.

²⁶ Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.

²⁷ Medibank, 'Hospital Experience scores' retrieved from <https://www.medibank.com.au/health-insurance/using-your-cover/going-to-hospital/hospital-experience-scores/>

patients more choice in the health services they receive and give patients access to health services close to their jobs, family, and community supports.

It is critical that the federal representatives and those in decision-making positions who care and value the health of regional Australians ensure we are able to maintain the viability of regional health services. CHA urges Government to consider the issues faced by regional Australians and the wider implications the currently trajectory of regional service provision will have for the health of Australians.

Implement measures that increase transparency and reduce the burden of out-of-pocket costs

Key Recommendations

- *Conduct a review from the consumer perspective with modelling that outlines the real costs associated with healthcare currently facing consumers.*
- *Enhance the provision of information to consumers to assist with pre-admission choice of doctor and improved understanding of charges that may be incurred, in both public and private hospitals.*
- *Prioritise research and funding for new models of maternity care across both public and private systems.*
- *Consultation with ministerial advisory committees and the health sector to ensure any form of price disclosure of medical services is conducted with due diligence.*

Within the health system, the development of significant out-of-pocket (OOP) costs to access medical and pharmaceutical services is eroding the universality of Medicare.

Expenditure by individuals on OOP costs and insurance co-payments was \$29.8 billion in 2016–17, and represents 16.5 per cent of total health expenditure.²⁸ This amounts to an average of \$1195 per person. This does not include ‘hidden’ fees, also known as shadow fees, sometimes charged by health professionals that are not reported.

OECD statistics published in 2017 reveal Australian households spend 3.1 per cent of their total household consumption on OOP medical costs, higher than the OECD average and higher than other comparable countries such as the USA, New Zealand, and the UK, who spend 2.5 per cent, 2.1 per cent and 1.5 per cent respectively.²⁹ While all Australians are deemed to have access to healthcare, the OECD reports that 16.2 per cent of Australians skip medical consultations due to cost; a much higher proportion than the OECD average of 10.5 per cent.³⁰ The AIHW reports an estimated 1.3 million people indicated that they delayed seeing a GP, specialist, imaging or pathology service when needed due to the associated cost.³¹

While both Medicare and the Pharmaceutical Benefits Scheme have safety nets, they are not linked, and have differing rules and thresholds. They are also complex and difficult to understand, whereby patients who qualify to access the safety net or a concessional rate under one scheme will not necessarily qualify under the other scheme.

In 2015–16, individuals spent \$29.8 billion on health-related expenses, accounting for 16.5 per cent of health expenditure, before receiving subsidies from the medical expenses tax rebate. Primary care accounted for more than two thirds or 67.8 per cent of this spending, while

²⁸ Australian Institute of Health and Welfare (AIHW) (2018), “Health Expenditure Australia 2017-18” Health and welfare expenditure series no. 64. Cat. no. HWE 74. Canberra: AIHW.

²⁹ OECD (2017) “How does Australia Compare?.” In Health at a Glance 2017: OECD Indicators, OECD Publishing, Paris

³⁰ Ibid.

³¹ Australian Institute of Health and Welfare (AIHW) (2018) “Patients out-of-pocket spending on Medicare Services Cat. no. HPF 35. Canberra: AIHW.

individuals spent 10.9 per cent on hospital cost. Hospital spending by individuals has more than doubled since 2006–07.³²

Specialist services contribute significantly to OOP costs in Australia. Statistics from Medicare show that in terms of total Medicare services, 78.9 per cent of providers' bulk bill, with bulk billing rates of GPs being 84.7 per cent. In comparison, the bulk billing rates for specialist services across Australia is only 31.1 per cent³³. For the financial year 2017–18, the average OOP cost for medical services was \$63.47. The average GP OOP fee was \$36.50, compared to specialist where the OOP cost was \$79.94.³⁴ Across the total range of services that fall under Medicare in 2015, approximately 19 per cent of services had OOP costs.³⁵ With rising rates of chronic disease and an ageing population that increasingly require specialist services, these numbers are set to rise.

The report *Patients out-of-pocket spending on Medicare Services* released by AIHW details that in 2016–17, half of Australian patients (10.9 million people) contributed an OOP payment to their out-of-hospital medical care. Regional disparities exist throughout Australia in the distribution of OOP costs. In 2017 the highest percentage of patients incurring OOP costs occurred in the ACT at 69 per cent compared to 31 per cent in the Northern Territory PHN. Variation occurs across regional and rural status with 48 per cent of people in metropolitan areas contributing to OOP compared to 53 per cent in regional PHNs. Specialists and obstetric services accounted for the highest OOP services with the median OOP cost for specialist services ranging from \$36 to \$97. The report also demonstrated difference in the amounts paid for a service based on location. OOP costs for diagnostic imaging were five times higher in the ACT compared to South Western Sydney.³⁶ This report highlights not only that OOP costs are increasing across Australia but also the increasing regional disparities, demonstrating a need for a consistent transparent approach for determining costs and educating consumers.

Obstetric services are one of the most significant contributors to rising OOP costs. Research by James Cook University revealed that expenses in obstetric services have grown by more than 1000 per cent in the last 25 years. In 2016–17 the average OOP obstetric cost for in-hospital services was \$781.07 and for out-of-hospitals costs \$264.08. This compares to the 1992–93 average, adjusted for inflation, of \$442.00 for in-hospital costs and \$23.35 for out of hospital. The largest increase was in out-of-hospital costs, which has risen by 1035 per cent with in-hospital costs rising by 77 per cent.³⁷ This has significant implications for the everyday consumer but is also upsetting the balance of the Australia's two-tiered private public system. Research recently conducted by CHA in conjunction with the University of Notre Dame has revealed that one of the primary reasons that consumers are choosing not to access private hospital maternity services are increasing costs.³⁸ These costs have also been associated with a declining rate of private health insurance uptake by younger Australians. The September 2018 APRA *Quarterly Private Health Insurance Statistics Report* indicates an overall drop in the number of people taking out

³² Australian Institute of Health and Welfare 2018. Health expenditure Australia 2016–17.

³³ See Austli, Commonwealth, Medicare Australia, "Annual Medicare Statistics" (Canberra: MA, 2017) at Table 1.1a, online: Department of Health.

³⁴ Ibid.

³⁵ Ibid.

³⁶ Australian Institute of Health and Welfare (AIHW) (2018) "Patients out-of-pocket spending on Medicare Services.

³⁷ Callander, E., Fox, H. *Changes in out-of-pocket charges associated with obstetric care provided under Medicare in Australia*, Australian and New Zealand Journal of Obstetric Gynaecology, 2018, 1–4.

³⁸ CHA Report

private health insurance (PHI) with the biggest decreases seen in the 30-34 age group with a decrease in coverage of 8473 individuals. The largest net decrease, accounting for movement between age groups, was in the 28-29 age group declining by 9616 individuals.³⁹ Maternity services have traditionally been an incentive for younger individuals to enrol in PHI, but as private maternity services among young people continue to decline, there is a likelihood that they may not enrol into PHI at all and risks putting substantial pressure on the already overstretched public system. CHA suggests that in order to address this growing issue, the government needs to prioritise research and funding for new models of maternity care across both the private and public systems.

CHA recommends the creation of measures that facilitate greater transparency around OOP costs. While the current bulk billing rates for total Medicare services stand at 78.9 per cent, current reporting mechanisms do not fully capture the additional costs or shadow fees from medical practitioners that patients experience. Consumers report being confused and often receiving bills for treatment that they believed were covered by Medicare or private health insurance policies. While the recent government announcement of the creation of the gold, silver, and bronze private health insurance policies goes some way to decreasing the complexity of private health insurance for consumers, it does not go far enough. Additional transparency is needed at all levels of healthcare, in both the public and private systems.

Whilst CHA advocates for greater transparency in OOP costs, any form of price disclosure from the medical profession must be undertaken with due diligence to avoid any negative effects from unintended consequences. CHA recommends an education campaign for the public to understand what bundled services might be involved in an episode of care and acknowledgement that higher price does not correspond to better quality care. There should also be rigorous oversight in the administration of any scheme to ensure the costs of healthcare are not artificially inflated and to manage any increases in shadow billing that might not be captured by current reporting arrangements.

CHA suggests a review to be undertaken from the perspective of consumers rather than funders—including modelling the real costs facing all consumers, but particularly those people with multiple chronic conditions. It should also model, where appropriate, the interactions with the welfare and tax systems.

³⁹Australian Prudential Regulation Authority (APRA) “Quarterly Private Health Insurance Statistics” September 2018 Sydney
https://www.apra.gov.au/sites/default/files/private_health_insurance_quarterly_statistics_september_2018.pdf

Growth of private patients in public hospitals

Key recommendations

- *Enforce compliance with the Medicare principles so that private patients in public hospitals do not receive quicker treatment or other preferential treatment to public patients.*
- *Remove hospitals' ability to offer inducements or to actively compel consumers to declare their private health insurance status (including waiving excesses and OOP fees, and using private patient liaison officers for the purpose of 'enhancing revenue').*
- *Enhance the provision of information to consumers to assist with pre-admission choice of doctor and improved understanding of charges that may be incurred in both public and private hospitals.*
- *Ensure that private patient election forms are submitted to the relevant health fund and that public hospitals provide Hospital Casemix Protocol data to insurers where private health insurance is claimed.*
- *Include provisions in the next public hospital funding agreement between the Commonwealth and states to ensure neutrality of funding for public and private patients, and to address the current funding incentives for public hospitals to maximise private patient activity. Level the playing field between public and private hospitals in terms of capital expenditure.*
- *Use available capacity within private hospitals more effectively to free up public hospital beds so that public hospitals can provide timely, high quality care to those who need it. Optimise the split of public and private hospital activity so that services are delivered in the most cost-effective and appropriate setting.*

CHA believes that it is imperative to maintain the balance of Australia's dual and interdependent hospital system to ensure equity of access to health services and the just allocation of health resources. CHA also supports the right of private patients to use public hospital services as a fundamental feature of Australia's health system.

The number of private patients in public hospitals has increased by an average of 10 per cent each year since 2008–09, almost doubling over this period from 451,591 to 871,902 in 2015–16. The cost of treating private patients in public hospitals has more than doubled over the period, from \$2 billion in 2008–09 to \$4.6 billion in 2015–16. Growth of private patients in public hospitals is outstripping rates of growth of public patients in public hospitals, and private patients in private hospitals.⁴⁰

The growth of private patients in public hospitals is having a deleterious impact on patients and other stakeholders within the system:

- There is growing inequity between public and private patients in public hospitals, with private patients receiving a number of inducements from public hospitals that are not available to public patients. There is evidence that public patients are waiting more than twice as long as private patients for treatment. A recent report published by the Australian Institute

⁴⁰ Catholic Health Australia, 'Upsetting the Balance: How the Growth of Private Patients in Public Hospitals is Impacting Australia's Health System', Canberra 2017.

for Health and Welfare⁴¹ breaks down median wait times for elective surgery in public hospitals from public waiting lists for patients with and without private health insurance by state for the last 4 years. There is a significant variation between states with public patients in New South Wales waiting on average for 62 days compared to those with private health insurance waiting for 21 days in 2016. In Victoria, the difference was 34 days for public patients compared to 19 days for those with private health insurance. In Queensland, the difference was 35 days for public patients and 20 days for private patients. Nationally, the difference in wait times is 42 days for public and 20 days for private patients. The report also shows a large variation in assigned urgency categories between those with private health insurance and those without.

- In addition to relatively stagnant private hospital growth—which is likely to further decline if current trends continue—there is not a level playing field between private and public hospitals to compete to attract private patients because of differences in how capital expenditure is funded.
- The growth of private patients is adding pressure to public hospitals which are already under strain, with failures to meet waiting time targets, and public hospital available capacity at its lowest level in the past 21 years.
- The growth of private patients in public hospitals leads to cost shifting from the states to the Commonwealth Government and private health consumers. Private health insurers spent \$1.1 billion on benefits for private patients in public hospitals in 2014–15, which is putting upward pressure on premiums.

The key driver of the growth of private patients in public hospitals is the practices of some public hospitals to encourage patients to use their private health insurance. It is important to note that there is wide differentiation in the behaviour of hospitals, which varies by state and by individual hospital. Whilst some hospitals have robust systems to ensure that patient rights are observed, others appear to be pushing the boundaries or engaging in unacceptable conduct such as waiving OOP fees, repeatedly asking patients to use their insurance, or providing additional services including free parking, washing services, better meal options, and more.⁴²

It has been suggested that patients are also receiving such inducements from private hospitals—for example, to encourage early discharge.

At least some of the practices described appear to directly violate the terms of the National Health Reform Agreement and potentially contravene privacy law and the *Competition and Consumer Act 2010*. Examples of such behaviour are highly concerning, and in conflict with the fundamental principles of Medicare.

⁴¹ Australian Institute for Health and Welfare, “*Private health insurance use in Australian hospitals, 2006-2016*”, Canberra December 2017.

⁴² Ibid.

These practices are driven by systemic incentives to maximise private patient activity, including:

- Public hospital funding arrangements whereby states set private patient or own source revenue targets.
- Fluctuations in the amount of Commonwealth funding for public hospitals.
- Private practice arrangements between public hospitals and doctors.
- The regulation of prostheses benefits for private patients.

Other factors influencing private patients to use public hospitals include the growth of OOP costs and exclusionary policies, and the improved amenity of public hospitals.

Although the evidence suggests that a significant proportion of private patients in public hospitals is substituting activity that would otherwise be public, it appears that at least a proportion of private patient activity in public hospitals is being attracted away from private hospitals. For example, in obstetrics there has been a substantial shift of activity from private to public hospitals in recent years.

CHA supports the right of private patients to use public hospital services as a fundamental feature of Australia's health system. There is a cohort of private patients who will legitimately need to, or choose to, attend a public hospital for reasons such as access, location and clinical profile. The Australian health system gives patients a choice of where to receive treatment, and it is vital that patients' choice to make a genuine election is retained. CHA advocates for all patients to be given the right to make a fully informed choice about their treatment, and that funding mechanisms do not create incentives to discriminate between public hospital patients based on ability to pay.

It is important to consider the overall funding implications of any proposed changes to current arrangements concerning private patients in public hospitals, as own source revenue currently represents a material proportion (around 10 per cent) of public hospital funding. If revenue generated from private patients is reduced, it is likely that states and public hospitals will need to compensate for this reduction from other funding sources. Governments should seek to ensure that funding mechanisms reflect just and effective stewardship of limited health resources for the common good.

Without action, it is likely that the current distortion of Australia's health system will continue, undermining the sustainability of Australia's mixed model of healthcare provision, and ultimately, the universality of Medicare.⁴³

⁴³ Ibid.