CATHOLIC HEALTH AUSTRALIA

HEALTHCARE Pre-Budget Submission 2018-19

CATHOLIC HEALTH
Australia

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

Constant renewal and reform is needed to ensure Australia maintains such a high quality health system that continually improves. This same report, released by The Commonwealth Fund, identified an area—standards of equity[2]—where the Australian health system lacked. The complex nature of Australia's two-tiered system—with interacting funding structures and competing stakeholder interests—is undermining Medicare's defining principle of universality. Pressures from an aging population and the increasing prevalence of chronic disease is driving need and costs, and creating an increasingly complex and siloed system. Consumers report being often confused, increasingly unable to access services, and dismayed by the lack of transparency regarding medical out-of-pocket (OOP) costs. Reform and improved communication mechanisms within Australia's healthcare system are needed before current methods become unsustainable.

CHA notes that radical reform of the current system is difficult to achieve. With this in mind, we believe that Australian health policy decision-makers should concentrate on making smaller improvements to our current health system in order to address persistent challenges. These include improving transparency around OOP costs, addressing disparities in the treatment of private patients in public hospitals, and allocating future funding to under-resourced health areas such as palliative care and public dental care, to help reduce inequity. CHA urges policy makers to prioritise the creation of a more transparent and equitable system. Some strategies for policy decision-makers to consider are outlined in this submission.

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

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[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/>

[2] Ibid.

Policy Area	Government Action Required
Transparency of out-of-pocket fees.	- 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.
Private patients in public hospitals	- Enforce compliance with the Medicare principles so that private patients 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. - 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 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. - 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 setting. - Level the playing field between public and private hospitals in terms of capital expenditure.
Funding and resourcing of palliative care	- Increase funding allocated to palliative care and community palliative care programs. - Incentivise and encourage training in end-of-life and palliative care for medical professionals and medical students. - Develop a public awareness campaign to educate the public on the benefits of palliative care, alleviate misunderstanding, and create a public conversation about death and dying.
Public dental	- Develop a public dental scheme that will progressively provide universal access to necessary primary dental health services.

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IMPLEMENT MEASURES THAT INCREASE TRANSPARENCY AND REDUCE THE BURDEN OF OUT-OF-POCKET EXPENSES

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.*

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.

Compared to the Organisation for Economic Co-operation and Development (OECD) average, Australia has a high proportion of health expenditure that is funded by individuals. In 2015, according to the OECD[3], individuals' OOP expenses contributed 17.3 percent of health expenditure in Australia, compared to only 10 percent in the UK and 13 percent in New Zealand. The share of health expenditure made up by OOP costs increased in Australia by 1 percent between 2008 and 2012. This does not include 'hidden' fees sometimes charged by health professionals that are not reported.

Australian households spend 3.1 percent of their total household consumption on OOP medical costs, higher than the OECD average and higher than other comparable OECD countries such as the USA, New Zealand, and the UK, who spend 2.5 percent, 2.1 percent and 1.5 percent respectively.[4] While all Australians are deemed to have access to healthcare, the OECD reports that 16.2 percent of Australians skip medical consultations due to cost; a much higher proportion than the OECD average of 10.5 percent.[5]

Expenditure by individuals on OOP costs and insurance co-payments was $29.4 billion in 2015–16, having grown in real terms by 1.3 percent from 2014–15.[6]

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. 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 $29.5 billion on health-related expenses before receiving subsidies from the medical expenses tax rebate. Primary care accounted for more than two thirds or 68 percent of this spending, while individuals spent 11.1 percent on hospital cost. Hospital spending by individuals has more than doubled since 2005–06.[7]

Specialist services contribute significantly to OOP costs in Australia. Statistics from Medicare show that in terms of total Medicare services, 73.8 percent of providers bulk bill, with bulk billing rates of

[3] OECD (2017) "Out of pocket medical expenditure." In Health at a Glace 2017: OECD Indicators, OECD Publishing, Paris.
[4] Ibid.
[5] OECD (2017) "How does Australia Compare?." In Health at a Glace 2017: OECD Indicators, OECD Publishing, Paris.
[6] Australian Institute of Health and Welfare (AIHW) (2016), "Health Expenditure Australia 2015-16" Health and welfare expenditure series no. 58. Cat. no. HWE 68. Canberra: AIHW.
[7] Australian Institute of Health and Welfare (AIHW) (2016), "Health Expenditure Australia 2015-16" Health and welfare expenditure series no. 58. Cat. no. HWE 68. Canberra: AIHW.

GPs being 84.3 percent. In comparison, the bulk billing rates for specialist services across Australia is only 30.7 percent[8]. For the financial year 2016–17, the average OOP cost for medical services was $60.97. The average GP OOP fee was $34.96, compared to specialist where the OOP cost was $75.22.[9] Across the total range of services that fall under Medicare in 2015, approximately 19 percent of services had OOP costs.[10] With rising rates of chronic disease and an ageing population increasingly requiring specialist services, these numbers are set to rise.

An additional complicating factor is the significant regional variation in access to bulk billing GPs and specialists. Data from 2011 shows that 85 percent 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 around half of this, with 61.1 specialists per 100,000 of the population, and was even worse in remote areas, with 15.5 per 100,000.[11] This puts people living in rural and remote areas at a significant disadvantage. With little competition in the market, anecdotal evidence suggests that specialists in these areas are able to charge excessive fees. Patients with limited alternatives are forced to pay excessive OOP costs, undermining their access to health care and in turn, the universality of Australian Healthcare.

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

CHA recommends the creation of measures that facilitate greater transparency around OOP costs. 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.

CHA suggests a review should 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.

[8] See Austl, Commonwealth, Medicare Australia, "Annual Medicare Statistics" (Canberra: MA, 2017) at Table 1.1a, online: Department of Health.
[9] Ibid.
[10] Ibid.
[11] Australian Bureau of Statistics (ABS)," Doctors and Nurses" 4102.0 - Australian Social Trends, April 2013, Canberra.

GROWTH OF PRIVATE PATIENTS IN PUBLIC HOSPITALS

Key Recommendations:

- *Enforce compliance with the Medicare principles so that private patients 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.*
- *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 setting.*
- *Level the playing field between public and private hospitals in terms of capital expenditure.*

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 percent 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. [12]

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, 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 for Health and Welfare[13] breaks down median wait times for elective surgery from public waiting lists for patients with and without

[12] Catholic Health Australia, '*Upsetting the Balance: How the Growth of Private Patients in Public Hospitals is Impacting Australia's Health System*', Canberra 2017.
[13] Australian Institute for Health and Welfare, "*Private health insurance use in Australian hospitals, 2006-2016*", Canberra December 2017.

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 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.[14]

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.

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.

[14] Ibid.

Although the evidence suggests that the growth of private patients in public hospitals is largely 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 is concerned to ensure that all patients are given the right to make a fully informed choice about their treatment, and that funding mechanisms do not create incentives to discriminate between 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 percent) 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. [15]

[15] Ibid.

IMPROVE ACCESS TO QUALITY PALLIATIVE CARE

Key Recommendations:

- *Increased funding should be allocated to palliative care and community palliative care.*
- *Training in end-of-life and palliative care should be incentivised and encouraged for medical professional and medical students.*
- *A public awareness campaign is necessary to educate the public about the benefits of palliative care and create discussions about death and dying.*

Palliative care in Australia is particularly subject to the vagaries of the delineation of funding and service responsibilities between the Commonwealth and the states/territories.

Quality palliative and end-of-life care have significant economic benefits. Patients who access palliative care are consistently shown to have fewer hospitalisations, shorter stays in hospital, reduced use of intensive care facilities and fewer admissions to emergency departments, amounting to significant savings for the health system.[16] There is also increasing evidence that appropriate end-of-life and palliative care reduces unnecessary testing and treatments. Currently in Australia, 'almost two-thirds of terminally ill people for whom home or hospice palliative care would be appropriate die in hospital, often receiving heroic interventions' that are frequently distressing and unnecessary.[17] Silver Chain Group, a leading provider of community based palliative care in WA, have estimated that the total amount saved in the last year of life for patients accessing their comprehensive palliative care services was $5,114 per patient in the period 2008–11.[18] The evidence is overwhelming that high-quality palliative and end-of-life care is best practice, cost saving, and highly effective as a life-preserving intervention.[19]

The *Productivity Commission Draft Report on Human Services* indicates that while Australia provides some of the best palliative care in the world, the vast majority of Australians are unable to access these services. More than 80,000 Australians die in hospital each year and 60,000 die in residential aged care facilities—two of the least preferred places to die.[20] Seventy percent of Australians indicate that they would prefer to die at home yet only 15 percent do, which is low compared to other OECD countries such as New Zealand, Ireland, France, United Kingdom and the USA.[21] A report from the Grattan Institute showed estimates from Palliative Care Australia calculated that 90 percent of cancer patients and 50 percent of non-cancer patients could benefit from additional palliative care services. This amounts to 100,000 people dying in Australia each year who need access to better palliative care.[22]

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[16] Palliative Care Australia, *The Economic Value of Palliative Care and End of Life Care,* Economic Research Note. Web. 13 Oct. 2017.
[17] Australia Government Productivity Commission 2017, '*Introducing Competition and Informed User Choice into Human Services: Reform to Human Services,* Draft Report, Canberra.
[18] Silver Chain, 'Silver Chain Group Submission on the Consolation Paper on the Pricing Framework for Australian Public Hospital Services 2016-17' (2015).
[19] Hudson P, Hudson R, Philip J, Boughey M, Kelly B, Hertogh C. L*egalizing physician-assisted suicide and/or euthanasia: pragmatic implications Palliative and Supportive Care.* 2015: 13 (5) p. 1399-1409.
[20] Australia Government Productivity Commission 2017, '*Introducing Competition and Informed User Choice into Human Services'.*
[21] Palliative Care Australia, '*The Economic Value of Palliative Care and End of Life Care'.*
[22] Swerissen, Hal and Duckett, Stephen 2014, '*Dying Well',* Gratin Institute.

The demand for community palliative care services far exceeds its availability in Australia.[23] It is estimated that 'many, perhaps tens of thousands of, people cannot access desired support to die in their own home and die in hospital instead.'[24] The specialist skills attributed to palliative medicine are currently neither commonplace nor incorporated into existing healthcare professional curricula. Specialist palliative care clinicians' account for five in every 1000 employed medical specialists in Australia, with an estimated 213 physicians in the entire country in 2015.[25] Nine out of 10 of these physicians work in major cities, further disadvantaging those who live in rural and remote communities.

Education is key to increasing awareness of palliative care for Australians who are unaware of the benefits that palliative care can have to relieve suffering, and provide a dignified death where they have control and their wishes respected. A public awareness of what services are available for end-of-life care is often not effectively communicated, resulting in misunderstandings and fear around palliative care. CHA is concerned that many people—especially those that are particularly vulnerable, such as Aboriginal or Torres Strait Islanders or older people—may mistakenly fear palliative care will hasten their death, and hence miss out on its benefits.

CHA believes that policy makers within state and federal governments should prioritise the adequate resourcing of end-of-life and palliative care, in conjunction with education and awareness raising for health care professionals, stakeholders and the community about the profound benefits of creating a world class palliative care system.

CHA proposes that the states be required to fund a minimum national standard of palliative care that sets out a minimum level of care that will be provided, regardless of where you live or the path of your journey through the health system.

CHA also calls on private health insurers to adequately fund palliative care for privately insured patients. One solution, as suggested in the 2015 Productivity Commission report[26], is to facilitate trials of expansions—informed by proposals from insurers—and evaluate these trials.

[23] Australia Government Productivity Commission 2017, '*Introducing Competition and Informed User Choice. into Human Services: Reform to Human Services,* Draft Report, Canberra.
[24] Ibid.
[25] Australia Institute for Health and Welfare, *Palliative care workforce.* Palliative care services in Australia, Canberra.
[26] Productivity Commission 2015, Efficiency in Health, Commission Research Paper, Canberra.

UNIVERSAL DENTAL INSURANCE

Key Recommendations:

- *Development of a scheme that will progressively provide universal access to necessary primary dental health services, noting that a funding mechanism—perhaps along the lines of a levy as proposed by the National Health and Hospital Reform Commission—will need to be established.*

CHA supports the concept of a national insurance scheme for dental. Oral health is an important component of general health as it ensures the basic fundamental needs of eating and communication. Recent reports highlight that general dental health in Australia is declining. Children's dental is a great predictor of adult dental health, and in 2010, data from public dental clinics across six states and territories showed that children's oral health is deteriorating. Fifty five percent of six-year-olds had experienced decay in their baby teeth. The average number of teeth affected had increased from 1.5 in 1996 to 2.6 in 2010. Forty eight percent of 12-year-olds had experienced decay in permanent teeth, with the average number of permanent teeth affected by decay increasing from 0.8 in 1996 to 1.3 in 2010.[27]

In 2013, it was found that on average people were missing five teeth, with the number of missing teeth increasing with age. Those aged between 15–24 years had on average two missing teeth, with people over the age of 65 years having on average of 11 missing teeth. It is interesting to note that those who had insurance had on average one less tooth missing than those who were uninsured.[28] The number of people who are uncomfortable with their dental appearance is also increasing, with 20 percent of people surveyed uncomfortable with their appearance in 1994, compared with 27 percent in 2013.

In 2013, 64 percent of people aged five years and over had made a visit to the dentist in the previous year. The cost of dental services in Australia is largely funded by individuals, with OOP costs contributing 58 percent of Australia's total expenditure on dental in 2012–13.[29] In 2013, the AIHW reported 77 percent of people with health insurance made co-payments for dental services and one in 10 insured consumers paid all their own expenses. Almost one-fifth of insured adults (19 percent) who were required to cover their own dental expenses said it caused a large financial burden.

Cost is one of the main drivers that leads people to neglect dental care. Of those people who needed to see a dental professional in 2016–17, 18 percent delayed seeking treatment or did not see a professional due to cost. This was compounded for people experiencing socioeconomic disadvantage, who were more than twice as likely to not seek treatment than those living in areas of least disadvantage—26 percent compared to 11 percent.[30] The principle of universality that has been an essential principle of Australia's healthcare system since the inception of Medicare is being undermined. Those who are disadvantaged socioeconomically are being excluded from appropriate dental care, which is affecting overall general health.

[27] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[28] Ibid.
[29] Ibid.
[30] Australian Bureau of Statistics "Key findings" 4839.0 - Patient Experiences in Australia: Summary of Findings, 2016-17, Canberra.