CATHOLIC HEALTH
Australia

Catholic Health Australia

Submission to the National Commission of Audit

Policy Paper: 26 November 2013

Table of contents

About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Executive Summary

Catholic health Australia (CHA) welcomes the opportunity to provide a submission to this Commission of Audit.

CHA's members provide around 10% of Australia's public and private hospital beds and 10% of Australia's residential and community aged care services. Taken together, our health services are bigger than those provided by the States of Australia, Tasmania, Australian Capital Territory and the Northern Territory.

Our portfolio of health and aged care services provides a unique perspective on the delivery of these services to Australians.

Health service demand and costs are expected to grow strongly over the coming decades as a result of the increasing incidence of non-communicable diseases, ongoing technological change and population ageing. Australian's health system, with its fragmented financing and health care service delivery, will struggle to meet these challenges in the absence of significant reform to funding and service delivery arrangements.

Funding needs to encourage best practice care in the right setting and ensure that access to care is not denied to the most vulnerable who are currently missing out. Increasingly, those who can afford to will need to contribute to the costs of their care.

Service delivery needs to be provided in the most efficient way possible by those organisations - whether public or private - that can most efficiently and effectively provide them. Cost benefit analysis will need to be deployed to ensure that public subsidy is only paid to those services that are cost-effective. Unnecessary and duplicated administrative burdens imposed on health service providers need to be minimised.

More needs to be done to help people stay well for longer and to ensure that social disadvantage leading to avoidable ill health is minimised.

Increased aged care services due to the ageing of the population will also add significantly to budget pressures in the medium and longer term.

There is scope to better manage these pressures and at the same time improve the quality of aged care services by the complementary measures of ending the current rationing of services and increasing contributions by those who can afford to pay for their care in return for full contestability in the system. Full contestability in service provision would in turn promote greater efficiency and innovation in service delivery and provide older Australians and their families with greater choice of more responsive services, including choice to receive care in their own home or in an aged care home.

Table of Recommendations

Health

1. That the Commission supports a move to reduce the fragmentation of health governance, finance and service delivery by moving to adopt a single stream of governance and funding through either the:
   a. establishment of regional health authorities; or
   b. adoption of a Medicare Select model based on an expanded role for private health insurers.

2. That the Commission supports:
   a. the restoration of private health insurance rebate as soon as it is fiscally responsible to do so;
   b. increased competition within the private health insurance market by enhancing the information available on the Private Health Insurance Ombudsman's website; and
   c. consumers having access to high quality health services regardless of their contract status with health insurers by ensuring 2nd tier default benefit rates are available for all jurisdiction and hospital types.

3. CHA calls for a review of the MBS and PBS safety nets to ensure they meet the objective of ensuring people from disadvantaged backgrounds are not denied access to necessary health care.

   The review should cover:

   a. qualifying thresholds;
   b. concessional rates;
   c. scope to integrate differing schemes covering the MBS and PBS;
   d. rates of people qualifying for the safety net across different geographic regions
   e. whether there is a role for small mandatory co-payments underpinned by effective safety nets to manage rapidly growing demand and ensure sustainable funding.

4. That the Commonwealth work with the State and Territories to ensure greater transparency and accountability of public hospital funding, including for maximizing

efficiency by undertaking greater market testing of services which may be more cost effectively performed in the non-government sector.

a. *The Commonwealth recognise the potential savings available by utilising the Catholic hospital system to deliver high quality hospital services.*

5. That the Commonwealth take the lead in working with the State and Territories to develop and enact a nationally consistent private hospital regulatory framework.

6. That the Commission supports the Independent Hospital Pricing Authority is establishing a formula for Commonwealth ABF payments that results in public hospitals having a neutral incentive in treating either public or private patients.

7. That the Commonwealth work with the State and Territories to lead a process of rationalising health data collections between the Commonwealth and States and Territories so as to remove any duplicated or otherwise unnecessary administrative burdens on health providers.

8. That decisions on the continuation of Commonwealth health agencies should have regard to the following principles:
   a. Is the function and work of the agency important to the operation of the Australian health system?
   b. Does the agency assist in ensuring the best use of the public and private resources devoted to health care?
   c. Does the work of the agency contribute to maximising the health status of Australians and minimising inequities in health outcomes?
   d. Does the agency provide value for money?
   e. Could the work be done more effectively or cost effectively elsewhere?
   f. What would be lost if the agency ceased to exist or its functions were moved elsewhere?

9. That the Commission supports ongoing rigorous reviews items funded under the MBS and PBS to ensure that items that attract public subsidy are actually effective and cost-effective. Payment models should also be examined to ensure that appropriate incentives are in place to deal with the increasing incidence of people living with multiple, complex and chronic disease.

10. Governments and the private sector need to champion best practice to ensure that health professionals are working to their full potential in order to deliver an adequate future health workforce.

11. Strategies to enhance productivity through workforce include:

    a. Implementing effective performance management across the sector to align workforce efforts with organisational outcomes
    b. Developing high performance workplaces, practices and organisational cultures that serve to engage employees and embrace new ways of working and problem solving.
    c. Ensuring that leadership capability is developed and put in practice within the right levels of the organisations so as to influence, define and drive performance improvements across the sector.

12. The industrial barriers to innovative practice must be addressed urgently.

13. The Government adopt the recommendations from the 2013 Senate Community Affairs Committee Report on the social determinants of health.

Aged Care

14. That the Commission that the Productivity Commission Report Caring for Older Australians provides a 'blue print' for reform of the aged care which will support higher quality aged care services while at the same time help to moderate future pressures on aged care outlays.

15. That the Commission **recommends** that the Government introduces the following measures to moderate the impact of an ageing population on aged care outlays in the medium and longer term, to increase contestability and consumer choice, and to increase equity in user contributions:

    a. Commit to a timetable for removing the current regulations that ration aged care services.
    b. Include the full value of the former principal residence as an assessable asset in the means test for aged care (with an appropriate taper).

c. Require a contribution to care by 'protected' residents, with appropriate security of tenure provisions for dependents, including dependents with long term disabilities.

d. Introduce equity in care contributions between home care recipients and residents of aged care homes who have similar income and assets and assessed care needs.

16. That the Commission **recommends** the development and introduction of a home equity release scheme that reduces exposure to financial risk risk for older people and their families in order to facilitate user contributions for aged care and avoid the forced sale of the former principal residence when a person needs to access aged care and support.

17. The Commission **recommends** that the Commonwealth Government hastens reforms that would encourage providers to deliver home care and support services that promote re-ablement and maximize and prolong independence.

SECTION ONE – HEALTH CARE

Context

Health is a major component of government spending (and spending growth) and hospitals are a major component of public health spending (and spending growth). CHA argues for the good stewardship of resources where health resources must be prudently developed, maintained and shared in the interest of all. CHA also has as one of its foundation principles a 'preferential option for the poor'. This stresses our concern for the provision of adequate timely health care for all, especially those who have little choice, opportunity or capacity to pay. For example low income households spend a higher proportion of income on health than high income households.

Any structural reform to the health system will need to identify 'poverty gaps' in the system and move to eradicate areas which leave people vulnerable and isolated from care. Broader economic reforms must enable all people to receive dignified care when they need it.

Demand drivers for health care

Demand for health care is rising rapidly driven by:

1. Non communicable diseases and social determinants of health
2. Impact and cost of new medical technologies
3. Ageing population

The health status of the population is itself an integral component to a strongly performing economy and will be a key factor in shaping the success of the government's economic and social objectives.

Non communicable diseases

Non communicable diseases (NCDs) such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes are the leading causes of mortality in the world.

Common modifiable risk factors often underlie the causes of NCDs – such as tobacco use, harmful use of alcohol, unhealthy diets, lack of physical activity, raised cholesterol, blood pressure and blood sugars and being overweight or obese.

In **Australia** - according to the World Health Organisation Non Communicable Disease Country Profiles 2011 - NCDs are estimated to account for **90% of all deaths**. 40% of Australians are physically inactive, 16% still smoke, 57% of Australians have high cholesterol, 63% of us are overweight and 26% are obese. In most middle and high income countries NCDs are responsible for more deaths than all other causes of death combined. These are sobering statistics and are the reason costs and demand for health care keeps rising.

There is now a concrete body of evidence that demonstrates that the conditions in which people are born, grow, live, work and age affect their health status – hence impacting on productivity.

There is also strong international evidence that health policy and health equity depend upon decisions made in sectors other than health and are linked to issues such as governance, environment, education, employment, food housing and transport.

The most important conclusion to be made about reducing the drivers of health demand is that action cannot be made in the health sector alone. Coordinated action across multiple sectors and portfolio areas is required. A healthier population improves the overall level of productivity in the economy, it increases

employment and helps to reduce poverty. Health is therefore a contributor as well as an indicator of development.

The lessons to be learnt about the relationship of NCDs and related social determinants of health is that NCDs are "proximal drivers" that are linked to broader social conditions, such as low and insecure income, poor housing and working conditions, poorly executed education policies and inadequate transport systems.

A World Economic Forum presentation in 2011 revealed that an investment of US$11billion spent on cost effective interventions against NCDs can prevent over US$47 trillion worth of future damage to the world's economies by 2030[1]. The NCD burden, a direct result of the "proximal drivers" of social determinants of health, if remained unchecked, will mean government budgets will become unsustainable and this will adversely affect economic and social development.

Poor social policies, unfair economic arrangements and government decision-making poor quality lead to unfair societies and inequitable health outcomes – and this leads to an increase in cost to government services, not just in health.

New Medical Technologies

New medical technologies are increasing the ability of the health system to extend both the quantum and quality of life. Whilst proven new technologies are often sought after by patients and providers alike, they generally come at a significant additional cost. For example, new medicines which are specifically tailored to an individual's genetic profile are likely to be more effective than a non-targeted medicine - but the process of individual tailoring and small batch sizes increases costs by removing the opportunity to gain economies of scale.

The Productivity Commission in its Research Paper on an Ageing Australia identified that costs per capita in healthcare tend to rise at around 0.6 to 0.9 percentage points above real GDP per capita growth - even for the same age cohorts[2].

Population ageing

Longer lifespans, which are a very positive outcome from a more effective health system, can also lead to additional health costs as more people, who would otherwise have died at an earlier age, continue to utilise health services. For example, as the Productivity Commission points out the cost of Pharmaceutical Benefits Scheme drugs per person aged 75 years or more was nearly 50 times greater than the cost per person aged under 18 years in 2010- 11[3].

As people in older age groups use more health services than those in younger age groups, the changing population mix will add to the increasing costs. This can be offset by people in older age groups being healthier than those in the same age group used to be in the past. An objective of government policy in an ageing society should be to help people stay healthy for longer.

A healthier older population is able to continue to contribute to society, including by remaining in the workforce for longer.

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[1] Bloom D, Caflero E, Jane-Llopis E, Abrahams-Gessel S, Bloom L, Fathima S et al *The global economic burden of non-communicable diseases*, Geneva, World Economic Forum, 2011

[2] Productivity Commission 2013, *An Ageing Australia: Preparing for the Future*, Commission Research Paper Overview, Canberra p 12

[3] Ibid p 12

OPTIONS TO IMPROVE HEALTH SYSTEM PERFORMANCE AND FUNDING

Health Funding and Governance

Australia's health funding and governance is highly fragmented. The absence of clarity of responsibility for outcomes, funding and decision-making results in gaps in service delivery, wasted resources and the shifting of cost and blame between different tiers of government that has become endemic within the Australian health system.

With limited resources and potentially unlimited demand for health services, it is imperative that the available resources are used in the most clinically effective and cost effective way to maximise the health outcomes across the community.

CHA proposes two options either of which would create a more cohesive and less fragmented governance and accountability framework.

These options are:

1) the creation of a single tier of government funder for publicly funded health services by establishing regional health authorities; or

2) the adoption of a Medicare Select type model where a single funder – public or private – would take responsibility for funding the full continuum of care across all care settings.

Either of the above options would involve significant change for the Australian health care system. CHA is not in a position to indicate a preference for one over the other. Detailed work would need to be undertaken to determine the potential benefits and pitfalls from each approach.

The failure of the previous government's health reform initiatives to bring to an end the cost and blame-shifting approach of current governance arrangements clearly demonstrates that a new, more integrated framework needs to be found.

Option 1 -<u>Single tier of government funder for publicly funded health services delivered through the establishment of regional health authorities</u>

CHA continues its very longstanding support for a single tier of government to take responsibility for funding publicly delivered health services and to be held accountable for health achievements.

Given the Commonwealth's financial position relative to states and territories, we have suggested that the Commonwealth should become the single funder. This does not mean that the Commonwealth would necessarily deliver health services; the Commonwealth would just be required to fund them and would be held accountable for outcomes. State governments and non-government organisations could still provide services – and we would suggest that continue to be the case given their expertise and experience

As a single funder, the Commonwealth would have an incentive to ensure that patients were treated in the most appropriate setting. The Commonwealth would also have to take responsibility for under-

funding. There would also be greater incentive to co-ordinate and support those public health campaigns that are best addressed on a national level such as smoking reduction.

Regional health authorities

CHA proposes that, under this model, the role of regional health authorities should expand to eventually become fully responsible for health outcomes in their areas - with a prime objective of reducing health inequities. This will require them to become geographic fund holders with the ability to commission the full range of health services in their regions.

The regional health authorities could be based on and grow out of the current local hospitals networks – or equivalents in each jurisdiction – although care would need to be taken to ensure that each authority was large enough to achieve economies of scale and effectively manage resources whilst remaining small enough to maintain their regional character and connection.

In the transition to a single funder arrangement, funding from Commonwealth and state governments that is currently used to fund acute, sub-acute, primary and community care should – over time – be increasingly directed through regional health authorities. The regional health authorities would then have the responsibility and incentive to purchase services from providers in the setting that is most appropriate for the needs of their patients.

The funding contribution from government will need to be based on an agreed, population-weighted, transparent formula.

Regional health authorities, in addition to assuming responsibility for commissioning health services for their total populations, should have as a key responsibility to improve population health and to reduce health inequities within their regions. This will require funding and delivery of services specifically targeted to those population groups bearing the greatest disadvantage. Funding to reduce inequities should be appropriately weighted to take account of the particular population characteristics and risk profiles of each local region.

The characteristics of vulnerable population groups will vary across the country. For example, the needs of those living in the inner city or in areas of high socioeconomic disadvantage will differ from those living in outer suburban or even rural and remote locations. Accordingly, the most appropriate ways to address health inequities will also vary. Regional health authorities should have the autonomy to develop the most effective options for their particular population groups within their geographic area.

Regional health authorities should also measure and report on the changes in both health status for their populations as a whole, as well as progress in reducing health inequities.

KPIs will need to be developed to specifically assess the health status of the most vulnerable populations. The KPIs could involve a mix of population health status as well as system metrics like access and clinical outcomes.

Regional health authorities should also be asked to report on the “wellness footprint” of their communities, including the impact of policies in areas such as urban planning, public transport, community connectedness and the physical environment on health outcomes.

Option 2 - Medicare Select

A different option to reduce funding fragmentation would be to expand the scope of coverage of private health insurance and require them to provide for all Australians products that span the full continuum of care from prevention through to high level tertiary care.

The National Health and Hospitals Reform Commission's final report released in 2009 recommended that the Commonwealth Government review the governance arrangements of Australia's health system by exploring the feasibility of establishing universal and competing, comprehensive health plans that could offer an alternative to the coverage provided to Australians under Medicare.

Under Medicare Select, Australians would be required to choose a health and hospital plan that best suited their needs. They would be able to choose to be insured by Medicare as a public plan or instead opt to be insured by a private health insurer or one operated by a not for profit organization. All Australians would receive a risk-adjusted subsidy to purchase comprehensive health insurance offered by one of the competing health insurance funds including Medicare.

Under the Medicare Select model, Medicare and competing health insurance funds would be required to offer coverage across all care settings; they would, in fact, become single funders in respect of their own members.

Other benefits from this model include providing the consumer with greater control of their health care choices, including being able to purchase access in a more timely way at the same time as encouraging providers to compete to offer high-quality, affordable care. This model would also provide incentives for private health insurers to work to keep their members as healthy as possible similar to that work that is undertaken by health insurers such as Kaiser Permanente the United States.

Whilst this option could provide a comprehensive, single funding stream for members, health care providers – both publicly and privately operated – would face the prospect of negotiating funding from multiple funders with different payment structures and rates, as is currently the case for private hospitals.

CHA believes there is merit in further exploring this option.

RECOMMENDATION

1. *That the Commission supports a move to reduce the fragmentation of health governance, finance and service delivery by moving to adopt a single stream of governance and funding through either the:*
    a. *establishment of regional health authorities; or*
    b. *adoption of a Medicare Select model based on an expanded role for private health insurers.*

Private Health Insurance

Rebates

Private health insurance plays an important role in enabling people to take greater responsibility for their health care requirements, providing choice and in easing pressures on the public hospital system.

CHA welcomes the current government's commitment to restoring the private health insurance rebates when it is fiscally prudent to do so. Rebates and incentives to take out and maintain private health insurance and leverages around $10 billion a year of additional funding from private individuals to health services that would otherwise need to be financed through the tax system. It will be important to monitor ongoing membership levels to ensure that rapid corrective action can be taken should the

previous government's changes to private health insurance arrangements result in a drop in either over all membership or in the levels of cover that private health insurance members hold.

The public subsidy provided to private health insurance also requires that coverage is provided only for evidenced based therapies.

Consumer information

CHA supports greater transparency and competitiveness in the private health insurance market - the provision of clear and concise information on private health insurance products, including exclusions and benefit limitations, available on the Private Health Insurance Ombudsman's website is an important resource for consumers. Additionally CHA considers that some standardisation of products – particularly in relation to exclusions and limitations would provide greater clarity and certainty for consumers.

2nd Tier Default Benefit

The 2nd tier default benefit arrangements ensure that consumers are able to continue to access high quality health services that may go out of contract with private health insurers. The arrangements also ensure increased competitiveness among health care providers and reduce the administrative burden for health insurers who may not want to negotiate detail contracts with a large number of smaller providers and day hospitals.

These arrangements should be kept in place - with the added requirement that 2nd tier default benefit rates are available for all jurisdictions and hospital types and ,made publicly avaialbe.

RECOMMENDATION

2. *That the Commission supports:*
    a. *the restoration of private health insurance rebate as soon as it is fiscally responsible to do so;*
    b. *increased competition within the private health insurance market by enhancing the information available on the Private Health Insurance Ombudsman's website; and*
    c. *consumers having access to high quality health services regardless of their contract status with health insurers by ensuring 2nd tier default benefit rates are available for all jurisdiction and hospital types.*

Patient co-payments

Reduce the burden of out-of-pocket costs for those that can't afford them

Within the health system, the development of significant out of pocket costs to access medical and pharmaceutical services is eroding the universality of Medicare and becoming a significant social issue.

Compared to the OECD average, Australia has a high proportion of health expenditure that is funded by individuals[4]. In 2009, according to the Australian Institute of Health and Welfare (AIHW), individuals' out-

[4] Australian Institute of Health and Welfare 2012. Health Expenditure Australia 2009-10 Supplementary Tables. Table 5.1

of-pocket expenses contributed 18.2 per cent of health expenditure in Australia compared to 14.4 per cent for the OECD countries as a whole. In the United States, this figure is 12.3 per cent[5].

AIHW data also shows that individuals' out-of-pocket expenses have been growing at a rate of 3.9 per cent above the rate of inflation in the six years to 2009-10.

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.

An additional complicating factor is the significant regional variation in access to bulk billing GPs and specialists. Low-income earners who have the misfortune to live in areas of low bulk billing are often subject to higher out-of-pocket charges – and ultimately reliance on the safety net – that people living in other geographic regions do not face.

For patients from disadvantaged backgrounds and for those with multiple chronic conditions, the need to spend up to a safety net threshold level can cause considerable hardship. Indeed, some may not be able to afford to pay the pre-safety net fees notwithstanding their clear clinical need.

CHA calls for a review of the various safety nets to ensure they meet the objective of ensuring people from disadvantaged backgrounds are not denied access to necessary health care.

The review should cover:

- qualifying thresholds;
- concessional rates;
- scope to integrate differing schemes covering the MBS and PBS;
- rates of people qualifying for the safety net across different geographic regions.

The review should be undertaken from the perspective of consumers– with modelling of the real costs facing people with multiple chronic conditions. It should also model, where appropriate, the interactions with the welfare and tax systems.

Whilst ensuring that the most vulnerable are able to access necessary health care, CHA considers there is scope to examine whether there is a role for small mandatory co-payments to be introduced in areas of health service demand that are growing rapidly, for example pathology tests or public hospital emergency department treatment that could otherwise be accessed through primary care at the same time in the same locality.

The co-payment would play a role in ensuring that rapid demand growth was clinically based, that those who can afford to contribute more were asked to do so and could provide an additional and sustainable funding source for services that are currently under-funded.

[5] Ibid The actual average amount of money paid by individuals for health service is higher in the US than in Australia, given that the US spent 17.4 per cent of GDP on health compared to Australia at 9.1 per cent

RECOMMENDATION

3. *CHA calls for a review of the MBS and PBS safety nets to ensure they meet the objective of ensuring people from disadvantaged backgrounds are not denied access to necessary health care.*

   The review should cover:

   a. *qualifying thresholds;*
   b. *concessional rates;*
   c. *scope to integrate differing schemes covering the MBS and PBS;*
   d. *rates of people qualifying for the safety net across different geographic regions*
   e. *whether there is a role for small mandatory co-payments underpinned by effective safety nets to manage rapidly growing demand and ensure sustainable funding.*

OPTIONS TO IMPROVE HEALTH SYSTEM EFFICIENCY

Greater transparency and contestability

As a provider of both public and private hospital services, CHA's members are able to see the strengths that hospitals in each sector can bring to the delivery of health care services.

CHA contends that the Catholic hospital system can provide public hospital services at significantly lower cost than many publicly owned and operated services.

Catholic hospitals have accountable systems of governance, strong management skills and scale operations. Additionally, as providers of public services, Catholic providers understand that they will not be bailed out in the event that they are not able to fulfil their contractual obligations in the event costs exceed what has been contractually agreed.

As an example, in Western Australia, St John of God Health Care has been contracted to build and run the 367 bed Midland Public hospital. The Western Australian government has stated that over the 23 year life of the project, the State will save around $1.3bn.

The Catholic hospital system, with its experience, history and current performance, is very well placed to greatly increase its role in provision of public patient services.

More generally, the 2009 study of public and private hospitals by the Productivity Commission[6] identified that around one-fifth of hospital services (Diagnosis Related Groups [DRGs]) had a cost per separation in public hospitals that was at least 10 per cent lower than in private hospitals, and nearly half of DRGs had an average cost in public hospitals that was more than 10 per cent higher than in private hospitals.

Clearly the health system as a whole could become more efficient if there was a greater ability to use those hospitals that are more efficient in the delivery of care.

[6] Productivity Commission 2009, Public and Private Hospitals, Research Report, Canberra.

RECOMMENDATION

4. *That the Commonwealth work with the State and Territories to ensure greater transparency and accountability of public hospital funding, including for maximizing efficiency by undertaking greater market testing of services which may be more cost effectively performed in the non-government sector.*

The Commonwealth recognise the potential savings available by utilising the Catholic hospital system to deliver high quality hospital services.

Consistent regulation of private hospitals

Private hospital regulation is a State/Territory responsibility, whilst regulation of private health insurance is undertaken at a Commonwealth level.

For private hospital groups, including CHA members, that operate across multiple jurisdictions, the inconsistency of private hospital regulation adds unnecessary administrative and legal costs. CHA proposes that the Commonwealth take the lead in bringing the jurisdictions together to develop and enact a nationally consistent private hospital regulatory framework.

RECOMMENDATION

5. *That the Commonwealth take the lead in working with the State and Territories to develop and enact a nationally consistent private hospital regulatory framework.*

Commonwealth Activity Based Funding for public hospitals to ensure neutrality of patient funding type between public and private patients

CHA considers that the introduction of Activity Based Funding (ABF) will improve efficiency in public hospitals – particularly in those jurisdictions relatively new to ABF.

Under the National Health Reform Agreement between the Commonwealth and States, the Commonwealth ABF payments, which represent around 40% of public hospital income provides an opportunity to ensure funding incentives are set in a way which provides a neutral incentive for public hospitals to treat either public or private patients.

More generally CHA considers that public hospital financing should not operate in a way that requires or incentives public hospitals to pursue private patients – particularly when public patients face long waiting times. Public hospital financing should ensure that public hospitals are appropriately paid for the work they do, including undertaking teaching, training and research. CHA considers the complex issues related

to public hospital financing are more likely to be resolved in a single public funding environment as proposed in CHA's Recommendation 1.

RECOMMENDATION

6. *That the Commission supports the Independent Hospital Pricing Authority is establishing a formula for Commonwealth ABF payments that results in public hospitals having a neutral incentive in treating either public or private patients.*

Collections of health data should minimise imposts on health providers

Hospitals face a high administrative burden in collecting and remitting data to a range of Commonwealth and State agencies and private health insurers.

Reporting of data is important in assuring the community that hospitals operate in a safe, transparent and accountable manner and are providing value for money. The requirement to report data – often covering the same subject areas but in different formats - to multiple agencies is expensive and diverts resources that could otherwise be devoted to clinical care. For hospital systems that operate across several jurisdictions this problem is amplified.

In the emerging digital age, governments should commit to adopting the principle of "collecting once; use often".

RECOMMENDATION

7. *That the Commonwealth work with the State and Territories to lead a process of rationalising health data collections between the Commonwealth and States and Territories so as to remove any duplicated or otherwise unnecessary administrative burdens on health providers.*

Commonwealth health portfolio agencies

CHA supports an examination of whether there is scope to rationalise the number of agencies currently in the health portfolio.

CHA proposes that decisions on the continuation of Commonwealth health agencies should have regard to the following principles:

- *Is the function and work of the agency important to the operation of the Australian health system?*
- *Does the agency assist in ensuring the best use of the public and private resources devoted to health care?*

- *Does the work of the agency contribute to maximising the health status of Australians and minimising inequities in health outcomes?*
- *Does the agency provide value for money?*
- *Could the work be done more effectively or cost effectively elsewhere?*
- *What would be lost if the agency ceased to exist or its functions were moved elsewhere?*

CHA considers that functions such as collection and analysis of data on health system performance and variations in health outcomes are very important and should be maintained – for example the recent reports by the National Health Performance Authority have highlighted unexplained and unacceptably large variations between regions in access to GPs, specialist and public hospitals.

The work of the Australian Institute of Health and Welfare in reporting on health status, health services, health expenditure and many other facets of the health system is vital to our understanding of how nearly 10% of Australia's GDP (most of which is publicly funded) is spent.

Whether multiple agencies are required to undertake this vital work is open to question.

CHA does not necessarily take the view that functions such as determining an efficient price for hospital services or reporting on health system performance should be undertaken within the Health Department whose prime function is to provide advice to the Commonwealth Minister. The nature of Australia's federation means that very robust negotiations often take place between Commonwealth and State/Territory departments over funding. The independence of agencies outside the processes of funding negotiations can result in those agencies developing more effective relationships across jurisdictions that are required to undertake objective analysis of system performance.

For the above reason, CHA also supports the continuation of the role of the Independent Hospital Pricing Authority outside the Department.

The collection and storage of data by agencies with different statutory underpinnings raises issues about access to data and protection of confidential commercial information from Freedom of Information requests. Any changes to the structure of Commonwealth health agencies will need to tread cautiously in this area and ensure that full stakeholder consultation takes place if changes are proposed.

In relation to primary care, CHA strongly supports the continuation of organisations that provide support for primary care providers including GPs, nurses and midwives and allied health practitioners. Ideally the boundaries of primary care support organisations would reflect the boundaries of local hospital districts. Ultimately consideration should be given to whether the functions of primary care support organisations should be rolled in with local health districts.

RECOMMENDATION

8. That decisions on the continuation of Commonwealth health agencies should have regard to the following principles:

a. Is the function and work of the agency important to the operation of the Australian health system?
b. Does the agency assist in ensuring the best use of the public and private resources devoted to health care?

c. *Does the work of the agency contribute to maximising the health status of Australians and minimising inequities in health outcomes?*
d. *Does the agency provide value for money?*
e. *Could the work be done more effectively or cost effectively elsewhere?*
f. *What would be lost if the agency ceased to exist or its functions were moved elsewhere?*

Ongoing entitlement programs

CHA supports the continuation of universal entitlement to the Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS). Nevertheless expenditure under these programs needs to be subject to ongoing rigorous examination of effectiveness and cost effectiveness to ensure that items that attract public subsidy are actually effective. Many technologies, once listed, tend to remain listed notwithstanding that they are displaced by more effective and cost effective technologies or further evidence reveals them to be less effective than was understood to be the case at the time of original listing.

Defunding of less effective items can be challenging for organisations that may have built business models around continuing subsidisation – this does not however justify ongoing public subsidy.

Payment models should also be examined for their incentives and impact. In particular our heavy reliance on fee for service payment mechanisms can result in fragmentation of care and can also provide incentives for over-servicing. As the incidence of people living with multiple, complex and chronic disease increases, CHA considers there is scope to make greater use of bundled and blended payment systems that provide incentives for effective management of ongoing conditions.

CHA also considers that Australians are still paying high prices for pharmaceuticals and medical devices compared with comparable overseas countries.

RECOMMENDATION

9. *That the Commission supports ongoing rigorous reviews items funded under the MBS and PBS to ensure that items that attract public subsidy are actually effective and cost-effective. Payment models should also be examined to ensure that appropriate incentives are in place to deal with the increasing* incidence of people living with multiple, complex and chronic disease.

Health Workforce – the key to making the health system work

The optimal deployment of the health workforce is a critical driver in delivering more efficient and effective health care. Ensuring the right mix of health professionals is available to meet the demands of the Australian population over the coming decades at a time of significant demographic change is going to be a major challenge.

It is CHAs view that priorities for a revised agreement with States and Territories and the Commonwealth should include explicit performance measures in relation to four key areas:

1. Innovation, by which we mean innovation in service models
2. Productivity including the application of technology and process design to achieve elimination of waste and improvement in the outputs and outcomes provided by hospitals and health services
3. Industrial issues including demarcation and other barriers to flexibility
4. International health professionals

Innovation

Innovation can drive efficiency and help to create a sustainable workforce. In the private sector it has been our experience that aligning of funding with patient outcomes has resulted in innovations that can be applicable across the health sector as a whole. Better aligning funding with patient outcomes would also improve quality and likely reduce costs.

Governments and the private sector need to champion best practice to ensure that health professionals are working to their full potential, not undertaking tasks that can be done by other lower skilled workers or by technology. This will be required in order to ensure an adequate workforce in future decades.

Future policy and initiatives need to be more proactive in exploring and promoting health profession role redesign. As the delivery of health services increasingly relies on members of multi-disciplinary teams working together, universities and training providers must better integrate courses for health professionals across discipline boundaries for non-discipline-specific subjects.

RECOMMENDATION

10. *Governments and the private sector need to champion best practice to ensure that health professionals are working to their full potential in order to deliver an adequate future health workforce.*

Productivity

Innovation is directly linked to productivity. This is evidenced by the fact that an ABS report recently released showed that businesses that pursued innovation were more than twice as likely to have improved their productivity, than those that didn't[7].

It is CHA's view that the Commonwealth and States/Territories need to show leadership in fostering increased productivity in the health workplace and that this should become a clear priority for the immediate future. This includes building evidence around those activities that result in enhanced

[7] Australian Bureau of Statistics: 8167.0 - Selected Characteristics of Australian Business, 2011-12 ;http://www.abs.gov.au/ausstats/abs@.nsf/mf/8167.0, accessed 19/9/13

productivity, and fostering of productivity enhancements such as the 'productive ward', the 'productive hospital' that address waste reduction.

Improvements in productivity are influenced by workforce, organisational infrastructure and investment and use of technology. Increasing the productivity of the workforce alone will not be sufficient to ensure an adequate future workforce but it is part of the equation.

Workforce drivers of productivity include competencies, skills, knowledge and experience of all employees.

Rigorous analysis of the strength of the impact of drivers of productivity and those strategies suggested should be undertaken to identify ways to manage and improve productivity. The NSW Public Service Commission is leading this work in the public sector in Australia at the moment, and there is likely much to be learnt from them.

Across both the public and private sectors there are a raft of untapped innovations that can be achieved through examining the architectural structure of health services and the processes that underpin them, as well as working actively toward the development of high performance workplaces. The range of strategies outlined should be made a high priority for government and be adopted and evaluated.

RECOMMENDATION

11. *Strategies to enhance productivity through workforce include:*
    - Implementing effective performance management across the sector to align workforce efforts with organisational outcomes
    - Developing high performance workplaces, practices and organisational cultures that serve to engage employees and embrace new ways of working and problem solving.
    - Ensuring that leadership capability is developed and put in practice within the right levels of the organisations so as to influence, define and drive performance improvements across the sector.

Industrial barriers

A further cause of fragmentation and lack of integration within the health system is the current sharp demarcation of boundaries between different occupational groups, i.e. work that has traditionally been undertaken by doctors as opposed to nurses or other allied health workers.

The continuation of these sharp boundaries, underpinned by the industrial relations system, not only works against integration of care but it is increasingly becoming unsustainable in view of projected workforce shortages over the coming decades.

Consideration needs to be given to whether existing demarcations and boundaries between occupations and professions are appropriate going into the future. In the context of emerging shortages of skilled health workers relative to increasing demand, we need to ensure that health professionals are able to work at the top extent of their skills.

New technologies provide the potential for the extension of professional boundaries to be undertaken in ways that maintain safe practice and at the same time free up the most highly skilled members of the

workforce to concentrate on those areas where their specialised skills can be most effectively be employed[8].

The industrial barriers to innovative practice must be addressed urgently with health services identifying the necessary changes and undertaking dialogue and negotiation with industrial organisations. Given the emerging workforce shortages it is important that workforce representative organisations agree and support the need to undertake quite significant restructuring of current occupational groupings.

RECOMMENDATION

12. The industrial barriers to innovative practice must be addressed urgently.

International Health Professionals

Australia relies heavily on international health professionals. There is an urgent need to support the provision of integrated information to health professionals arriving from overseas and to students, trainees and health professionals as their migration, educational and professional status changes while in Australia.
In particular many highly qualified overseas trained professionals have experienced difficulty in gaining recognition to practice in Australia. In some cases supervision has been an issue – this can be problematic when the individuals concerned are already at the top of their profession internationally.

Social Determinants of Health

In 2012, CHA commissioned a report from NATSEM: The Cost of Inaction on the Social Determinants of Health The report explored the important issue of the social determinants of health and the impact on health outcomes, including the economic impact. Key findings suggested that if the WHO recommendations were adopted in Australia then:

- 500,000 Australians could avoid suffering a chronic illness;
- 170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments could be made;
- 60,000 fewer people would need to be admitted to hospital annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.

[8] Catholic Health Australia Health Policy Blueprint: http://www.cha.org.au/images/policy/CHA%20Health%20Blueprint.pdf, p.16

RECOMMENDATION

13. The Government adopt the recommendations from the 2013 Senate Community Affairs Committee Report on the social determinants of health.

SECTION 2 - AGED CARE

As noted earlier in this submission, the structural ageing of Australia's population will:

- significantly increase Commonwealth Government spending in the areas of health, age-related pensions and aged care; and
- Be a prominent contributor to structural pressures on the Commonwealth Budget in the medium and longer term.

This budgetary dynamic was documented by the first Commission of Audit in 1996, and has been confirmed in each of the Intergenerational Reports.

Aged care is a relatively modest contributor in absolute terms to these pressures compared with the impact of health spending. Nonetheless, the projected growth in Commonwealth outlays on aged care is significant in its own right, with the most recent Intergenerational Report (2010) projecting an increase from 0.8% of GDP in 2010 to 1.8% of GDP by 2050.

There are, however, well considered policies already 'on the table' which, if implemented, would moderate the impact of an ageing population on aged care outlays in the medium and longer term. These policies would also improve access to quality aged care services that are more responsive to consumer needs and preferences.

What are the policy options?

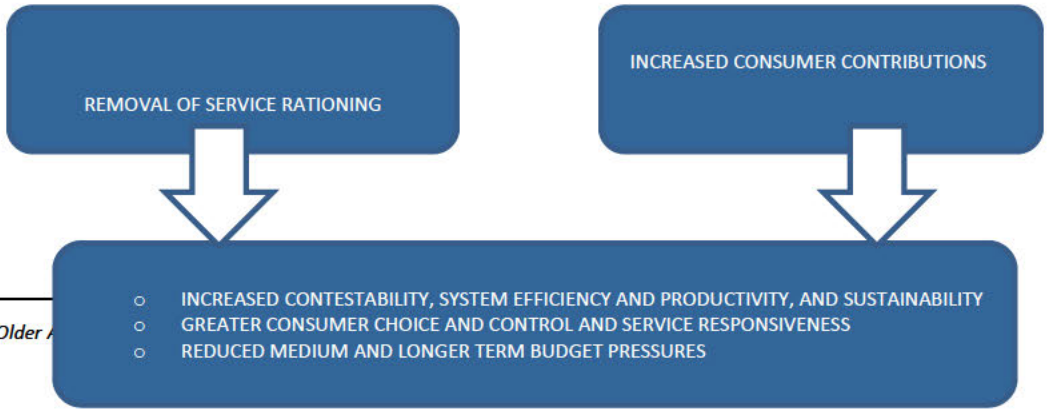
Amongst the first formal processes to document the policy options was the first Commission of Audit, which identified that there was scope to moderate the impact on Budget outlays by extending user charging through means testing and by introducing contestability among aged care providers.

More recently, the recommendations of the most comprehensive inquiry into aged care services in Australia, the Productivity Commission's report *Caring for Older Australians*,[9] developed and extended these policy options.

Put simply, the Productivity Commission recommended complementary reform measures that would improve the sustainability of aged care services by ending the current rationing of services and increasing contributions by those who can afford to pay for their care in return for full contestability in the system.

Full contestability would in turn promote greater efficiency and innovation and provide older Australians and their families with greater choice of more responsive services, including choice to receive care and support in their own home or in a residential facility.

The essence of the Productivity Commission's concept for moderating aged care pressures on the Budget is illustrated in the diagram below.



[9] *Caring for Older A*

Progress with implementing the Productivity Commission's policies

The former Government's reform package in response to the Productivity Commission's recommendations, legislated in July 2013, did not accept the recommendations in full, but made progress.

As a result of the package:

- the service provision target will be increased over ten years (from 113 places per 1,000people aged 70 years and over to 125 places by 2022);
- the regulated proportion of the overall provision target reserved for services that will be delivered in a person's home (home care)will also increase by 2022 from 25% to 36%;
- an income test will be introduced in home care;
- a new combined income and assets test will apply in residential care, whereas previously separate income and asset tests applied; and
- a lifetime cap ($60,000) on individual contributions towards the cost of personal and nursing care will be introduced to avoid unpredictable catastrophic costs, consistent with social insurance principles.

The increase in the overall provision target and the increase in the proportion of home care places will see some improvement in consumer choice and contestability, and the changes to the means testing arrangements will result in a modest increase in consumer contributions towards the cost of their personal and nursing care.[10] The additional contributions are estimated by 2016-17 to rise to about $300 million compared with Commonwealth care subsidy outlays of over $12 billion.[11]

The Parliament also legislated for an independent review of the package to be undertaken after 2016, including the means testing arrangements and the continuation of service rationing. The review's report is required to be tabled in Parliament.

The changes above are an improvement but they fall short of the Productivity Commission's recommendations by:

- not committing to a timetable for the removal of rationing which would give the sector and financiers necessary certainty about a move to full contestability and consumer choice; and
- not fully accepting that those who are able to should contribute more towards their personal and nursing care in line with their total wealth, while still leaving the Government responsible for caring for those with limited means and still meeting a significant proportion of the nursing care costs of those with greater means, consistent with social insurance principles.

By continuing the control over the number and mix of services through caps on the availability of residential and home care services, the negative consequences of service rationing which the Productivity Commission sought to consign to history will continue to be a feature of the aged care system.

[10] Note that aged care regulations distinguish between personal and nursing care and accommodation. While the increase in user contributions for personal and nursing care is modest, a separate reform measure will see the removal of the current cap on accommodation prices that apply in residential high care (the accommodation charge). Instead providers will be able to charge eligible residents prices in line with the underlying value of the accommodation, with the determination of the value governed by regulations.

[11] Living Longer Living Better Australian Government April 2012 page 38

Namely:

• constraints on timely access by consumers and their families to care and support services of their choice received in accommodation of their choice (including in their own home);
• an expensive regulatory apparatus in the Department of Social Services to administer service rationing that frustrates providers by imposing bureaucracy and red tape and reduces flexibility and creates inefficiencies; and
• the dilution of contestability and consumer choice that in other sectors of the economy are critical for fostering service quality, responsiveness to consumer preferences, innovation and productivity which together would help moderate medium and longer term pressures on the Budget.

The former Government's reforms to means testing arrangements are an improvement, but there is more that can be done to help moderate pressures on outlays and address inequities in the current arrangements. In this regard, the following features of the arrangements are candidates for reform.

- The arrangements exempt all but $144,500 of the value of the former principal residence from the new combined income and assets test in residential care if the residence is retained. If there is to be a meaningful contribution towards aged care costs in line with capacity to pay based on total wealth, the full value of the former residence should be treated as an assessable asset.

Illogically and inequitably, however, the $144,500 cap will not apply if the former principal residence is sold and the wealth formerly represented by land, bricks and mortar is converted to any other form of wealth, including any paid to a provider in the form of a Refundable Accommodation Payment. At the same time, rental from a retained former principal residence is not assessable income, whereas any interest earned from investing any surplus proceeds from the sale of the residence is assessable income.

The combined effect of the above arrangements is to discriminate against a person who for whatever reason sells their former house and to forego user contributions that could be requested in line with capacity to pay.

- They continue to exempt a resident from contributing to their accommodation costs if a dependant lives in the principal residence, irrespective of its value. Changes in this area would need to ensure security of tenure for dependents, including dependents with long term disabilities.

- They unfairly require a person being cared for in an aged care home to pay considerably more towards their personal and nursing care (which excludes accommodation costs and living expenses) than someone with similar care needs and wealth living in their own home.

It is noteworthy that any extension of the scope of means testing would operate in parallel with the cap on annual lifetime care contributions to apply from 1 July 2014 to protect people from excessive care costs.

RECOMMENDATION

14. *That the Commission **notes** that the Productivity Commission Report Caring for Older Australians provides a 'blue print' for reform of the aged care which will support higher quality aged care services while at the same time help to moderate future pressures on aged care outlays.*

15. *That the Commission **recommends** that the Government introduces the following measures to moderate the impact of structural ageing of the population on aged care outlays in the medium*

and longer term, increase contestability and consumer choice and to increase equity in user contributions:

a. *Commit to a timetable for removing the current regulations that ration aged care services.*
b. *Include the full value of the former principal residence as an assessable asset in the means test for aged care (with an appropriate taper).*
c. *Require a contribution to care by 'protected' residents, with appropriate security of tenure provisions for dependents, including dependents with long term disabilities.*
d. *Introduce equity in care contributions between home care recipients and residents of aged care homes who have similar income and assets and assessed care needs.*

Home equity release arrangements

The common theme in the above arrangements is that increased contributions would be based on making the former principal residence as an assessable asset, recognizing that most of the wealth of the majority of older Australians is represented by home ownership, a tax free asset.
The Productivity Commission recognized that extending the scope of means testing in this way poses a problem for people receiving home care, partners continuing to live in the former home and residents and their families who prefer not to sell their former residence. It is important that the new arrangements do not result in the forced sale of the house when a person needs aged care and support.
Accordingly, the above changes in means testing arrangements should be accompanied by home equity release arrangements which older Australians can access with confidence that they will not be exposed to financial risks, such as the arrangements (a Home Credit Scheme) recommended by the Productivity Commission.[12]

RECOMMENDATION

16. *That the Commission recommends the development and introduction of a home equity release scheme that reduces exposure to financial risk in for older people and their families order to facilitate user contributions for aged care and avoid the forced sale of the former principal residence when a person needs to access aged care and support.*

A greater role for reablement

As well as introducing full contestability and more appropriate user contribution arrangements, the structural pressures on the Budget from an ageing population can be moderated by placing greater emphasis on support services that are designed to restore or prolong an older person's independence, rather than defaulting to providing care and support on an ongoing basis. The recipients of assistance under the Home Support Program (formerly known as the Home and Community Care Program) in particular would benefit from such a change of focus.

The effectiveness of a re-ablement approach has been evaluated with positive results, most recently by research in Australia.[13] Prior to this the Productivity Commission also identified reablement as a means of making more effective use of aged care funding, and recommended that a reablement service be introduced to give greater focus on independence, rehabilitation and restorative care.

RECOMMENDATION

[12] *Caring for Older Australians* Productivity Commission June 2011 (Recommendation 8.1)
[13] *Evidence for the Long Term Effectiveness of Home Care Reablement* Programs G Lewin, H Alfonso and J Alan Dovepress Clinical Interventions in Ageing 2013

17. *The Commission recommends that the Commonwealth Government hastens reforms that would encourage providers to deliver home care and support services that promote reablement and maximize and prolong independence.*