

606 MINISTER FOR HEALTH'S ITEM (John Hill) - NOTED

Not relevant



606

Minutes forming Enclosure to:

07SPP/0450

**TO: THE PREMIER FOR CABINET TO NOTE**

**RE: CARING FOR OUR HEALTH? - A REPORT CARD ON THE AUSTRALIAN GOVERNMENT'S PERFORMANCE ON HEALTH CARE**

**1. PROPOSAL**

- 1.1 That Cabinet notes the attached document, *Caring for Our Health? – A report card on the Australian Government's Performance on Health Care.*

**2. BACKGROUND**

- 2.1 At the Council for the Australian Federation meeting on 9 February 2007 a set of principles was endorsed to guide continuing health care reform and particularly the negotiations over the Australian Health Care Agreements. At that meeting, it was also agreed that all States and Territories would undertake work, through their Health Ministers in consultation with First Ministers, to identify viable options for improving outcomes for Australians on health care.
- 2.2 States and Territories have been working together to consider a range of strategies to inform negotiations in the lead up to the next Australian Health Care Agreement.
- 2.3 Under the current Agreement the Australian Government publishes an annual report on the performance of public hospitals across Australia, *the State of our Public Hospitals Report*. It has been noted that there is no equivalent report on the Australian Government's performance in relation to the health care services that fall within its responsibility. It should also be noted that the performance of public hospitals cannot be considered outside the context of the performance of the rest of the health care system, such as general practice, specialists and pharmaceutical benefits.
- 2.4 In response to this gap in performance accountability, it was agreed that States and Territories would work together to prepare a report on the Australian Government's performance on health care to coincide with the release of the next *State of our Public Hospitals Report* (to be released 29 June 2007).

**3. DISCUSSION**

- 3.1 The key messages in *Caring for our Health?* are;
- 3.1.1 People find it harder to see a GP than ten years ago. There are relatively fewer GPs, they work shorter hours and they are concentrated in major cities.

- 3.1.2 The cost of seeing a GP has risen over the past ten years, as fewer GPs bulk-bill and the Australian Government's schedule fees have not kept pace with inflation. Bulk-billing rates for specialists working in private practice are also low and falling.
- 3.1.3 The Australian Government is paying a smaller and smaller share of public hospital funding each year. In 2000, it contributed 50 per cent of the cost of running and maintaining public hospitals. In 2005, that share had dropped to 45 per cent.
- 3.1.4 The Australian Government is now paying the States and Territories for public hospitals approximately \$1.1 billion a year less than recommended by an independent arbiter. If the full amount recommended was paid, public hospitals around the country could manage an extra 350,000 admissions a year.
- 3.1.5 If the trend continues, then in 20 years time the Australian Government's share of public hospital funding will have declined to about 25 per cent, and the States' and Territories' share will have risen to about 75 per cent. This would affect the States' and Territories' ability to look after other essential services, such as schools, police, public transport and roads.
- 3.1.6 The private health insurance premium rebates cost more than \$3 billion last year. Some of the \$3 billion goes towards management costs. At the same time the health insurance funds made a profit of almost \$1 billion.
- 3.1.7 The Australian health workforce is ageing, which raises serious questions about how health services are to be provided in the future.
- 3.1.8 The attached document is subject to change following final consultation with the States and Territories.

#### 4. RECOMMENDATIONS

- 4.1 That Cabinet notes the attached document *Caring for our Health? – A report card on the Australian Government's performance on health care.*

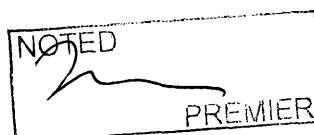
  
MINISTER FOR HEALTH

Date:

15/6/07

**In Cabinet**

18 JUN 2007



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# **Caring for our health?**

## **A Report Card on the Australian Government's performance on Health Care**

**A report by state and territory health ministers**

**Version 16: June 15 2007**

Working draft – no official status

Strictly not for circulation or citation

Caring for our health? – version 15

RaggAhmed

June 12

## Foreword

The Australian Government spends nearly \$42 billion a year on health care. That's a lot of your money.

It supports, subsidises and pays for vital elements of the health system – general practitioners, specialists, medicines, public hospitals, private hospitals, aged care, the training of doctors, education of nurses ... it's a long list. The Australian Government also subsidises, to a large and growing extent, private health insurance.

But where does all this taxpayers' money go?

*Caring for our health? Fairness and Australian Government spending* presents a comprehensive snapshot on national health funding in an easy to understand format. This report details for the first time where Canberra is spending your money and how much goes to the private health sector. It focuses on Medicare, general practitioners, specialists, medicines, public hospitals, private health insurance and explores health funding needs into the future. It examines whether recent changes in Australian Government policy are directing money where it is most needed. Most of the information is national – there may be some variations in different parts of Australia.

We, the eight state and territory health ministers, have produced this report to keep the Australians fully informed. We believe governments should be open, transparent and accountable with taxpayer's money. You have a right to know where the money you contribute through taxes is being spent. We believe that the more governments are open and accountable the more effective they are. This also applies to your health system.

We also believe the Australian Government should have released this information already. It has not. So we will.

names of ministers to come

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## Summary

- People find it harder to see a GP than 10 years ago. There are relatively fewer GPs, they work shorter hours and they are concentrated in major cities.
- The cost of seeing a GP has risen over the past 10 years, as fewer GPs bulkbill and the Australian Government's schedule fees have not kept pace with inflation.
- Specialists are highly concentrated in cities, and many rural people have difficulty seeing them.
- The cost of seeing a specialist is rising. Bulk-billing rates for specialists working in private practice are low and falling.
- We have almost no information on the cost of private specialist services in private hospitals.
- The Australian Government is paying a smaller and smaller share of public hospital funding each year. In 2000 it contributed 50% of the cost of running and maintaining public hospitals. In 2005 that share had dropped to 45%.
- The Australian Government is now paying about \$1.1 billion a year less than recommended by an independent arbiter. If it paid the full amount recommended, public hospitals around the country could manage an extra 350,000 admissions a year.
- If the trend continues, then in 20 years' time the Australian Government's share of public hospital funding will have declined to about 25%, and the states' and territories' share will have risen to about 75%. This would affect the states' and territories' ability to look after other essential services such as schools, police, public transport and roads.
- The safety net payment scheme is complex, and favours those who can afford to pay doctors' fee in full. Safety net payments go mainly to those most able to pay medical expenses. When those least able to afford

medical expenses do receive safety net payments, they are lower than average.

- We do not know whether this is an aim of the Australian Government's policy, or merely a result of it.
- The cost of the Pharmaceutical Benefits Scheme is rising rapidly for the Australian Government and for individuals. The rising costs are being shared.
- State and territory governments fund medicines in public hospitals so we, too, are feeling the effects of price rises.
- The number of scripts being filled has fallen in the past year. This may be due partly to the Australian Government's decision to increase out-of-pocket costs for prescription medicines.
- The private health system is not always complementary to the public health system – recent changes have made it more attractive to younger, wealthier and healthier people in preference to older people.
- The private health insurance premium rebates cost more than \$3 billion last year. Some of the \$3 billion goes on management costs. At the same time the private health insurance funds made almost \$1 billion in profit.
- In the past eight years, private health insurance funds have increased their wealth by almost \$3 billion, while premiums have risen at roughly double the rate of inflation. Profits have risen dramatically.
- There is no evidence that the subsidy of private health insurance reduces the pressure on public hospitals.
- The Australian health workforce is ageing, which raises serious questions about how health services are to be provided in the future.
- The Australian health workforce is also concentrated in cities, which means people living in rural areas often have trouble getting health care.
- The costs of health care for the average person are rising rapidly. Overall, even after taking inflation into account, people are spending over 5% a year more on health care.

- Health care is becoming more expensive, and more of it will be needed as the population ages. The health system was designed for people with short-term illness, yet most of its time is spent looking after people with chronic, long-term illnesses. On top of this, the shortage of health professionals is likely to get worse.
- Is the Australian Government doing enough to care for our health, both now and in the future?

# 1: Introduction

The Australian health system involves a lot of people – about 230,000 nurses, 70,000 nursing assistants, 60,000 doctors, 23,000 dental assistants, 15,000 pharmacists, 14,000 physiotherapists, 9,000 dentists, 9,000 health service managers, 8,000 occupational therapists and 2,000 podiatrists (as well as other personnel).

Some of these people work for themselves. Others work with colleagues. Some work in the public sector. Others work in the private sector. Some work to prevent health problems arising. Others deal with them once they are there. Some manage patients. Others manage services.

There are public hospitals, private hospitals, community health services, specialised health clinics and private practices.

There are programs aimed to reach everybody, like Medicare and the Pharmaceutical Benefits Scheme. There are programs aimed to reach those with special needs, such as palliative care services, dementia services and HIV services.

The Australian health system is complex. Its funding is complex too. But in very simple terms, the funding of the Australian Government's component works like this.

The Australian government collects money from Australians through individual taxation, business taxation, the goods and services tax and the Medicare levy.

It gives the state and territory governments a certain amount of money each year for health care – some of it in general funding and some of it tied to particular areas, such as public hospitals.

The Australian Government also spends a significant amount of money on the health system, although it does not provide any services itself. It subsidises your (mainly out-of-hospital) visits to doctors through the Medicare Benefits Schedule. It subsidises a range of medicines through the Pharmaceutical Benefits Scheme. It subsidises the cost of aged care through paying some of the cost of nursing home beds and community services. It subsidises the cost of private health insurance through a rebate scheme.

Caring for our health? – version 15

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June 12

The rest of this document examines this spending by the Australian Government. It asks two basic questions. What are you getting for your money? And is it fair?

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## 2: General practitioners

General practitioners are the cornerstone of the health system. About 85% of Australians see a GP each year – they are the first and most important on-going contact with the health system for most people.

In many cases, GPs provide the guidance and support to help people navigate their way through the health system.

The Australian Government, to a large extent, underwrites the funding of general practice. It sets a fee for a visit to a GP, although the GP does not have to stick to this amount. However the Medicare rebate is based on that set fee. Doctors can decide to accept the Medicare rebate as the full payment for their service – this is known as bulkbilling – or they can charge their own fee. If they do so, their patients then claim back some of the money they paid from Medicare.

Following is a series of figures which lay out how many general practitioners there are in Australia, where they are, the extent of Australian Government funding of their services, the extent to which individuals pay for their services and the extent to which GPs are bulkbilling.

### How many GPs are there, and where?

The number of GPs in Australia has remained fairly stable for some years, even though the population is growing and getting older. This means, in effect, that there are fewer GPs per person, as shown in figure 1.

Where do they work? They are reasonably well spread throughout cities and rural regions, although there are shortages in some areas such as the less wealthy areas of some cities. Not nearly as many GPs work in remote regions of Australia. As shown in figure 2, the further you are from a capital city, the fewer GPs per person.

Figure 1: Number of GPs per 100,000 people

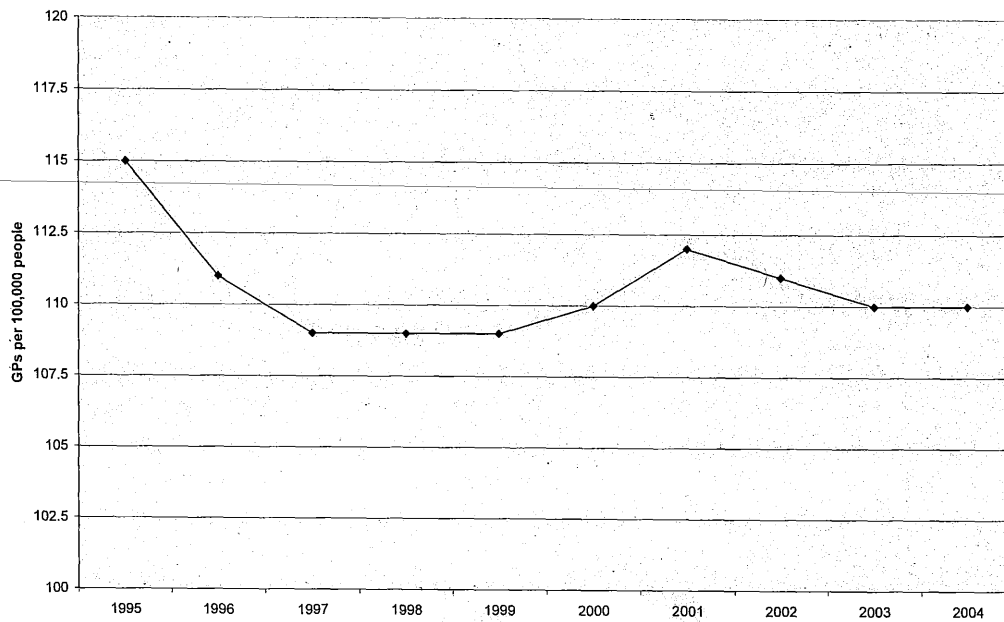
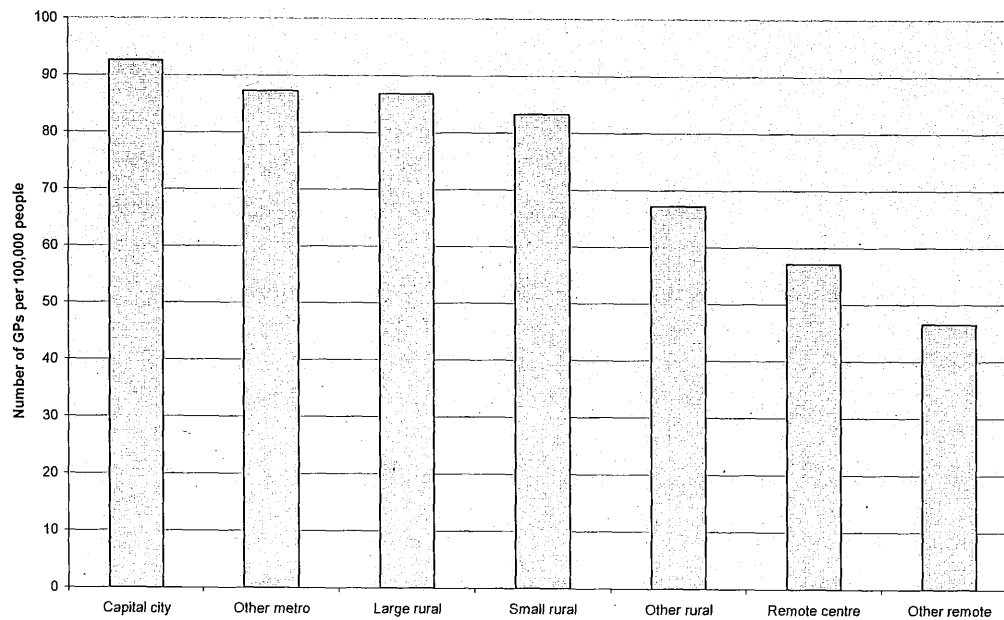


Figure 2: GPs per 100,000 people by geographical region



## Who pays to see a GP, and how much?

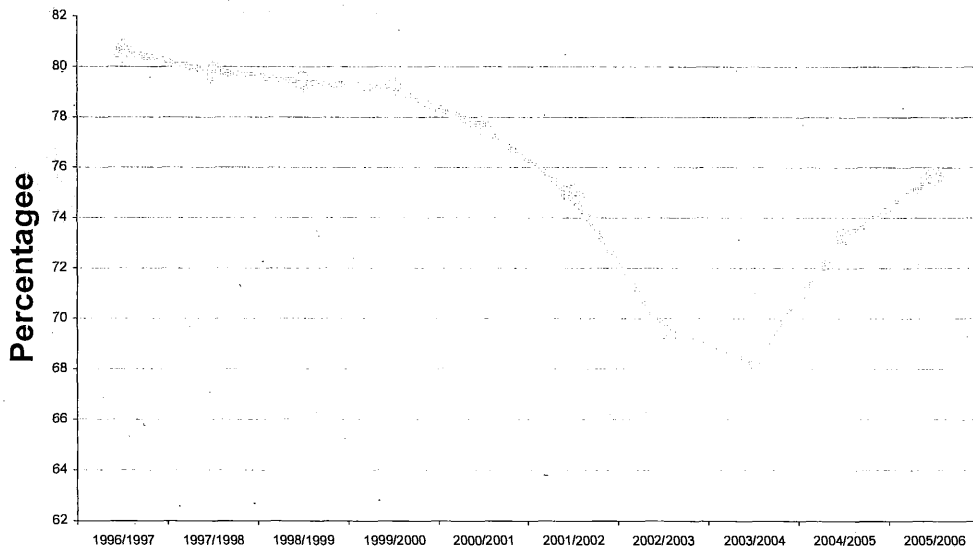
Whether or not a GP charges a patient anything more than the Medicare rebate is a matter for the doctor to decide.

In 1996/97, more than 80% of visits to GPs were bulkbilled. Fewer than 20% of people visiting a doctor had to pay anything from their own pocket.

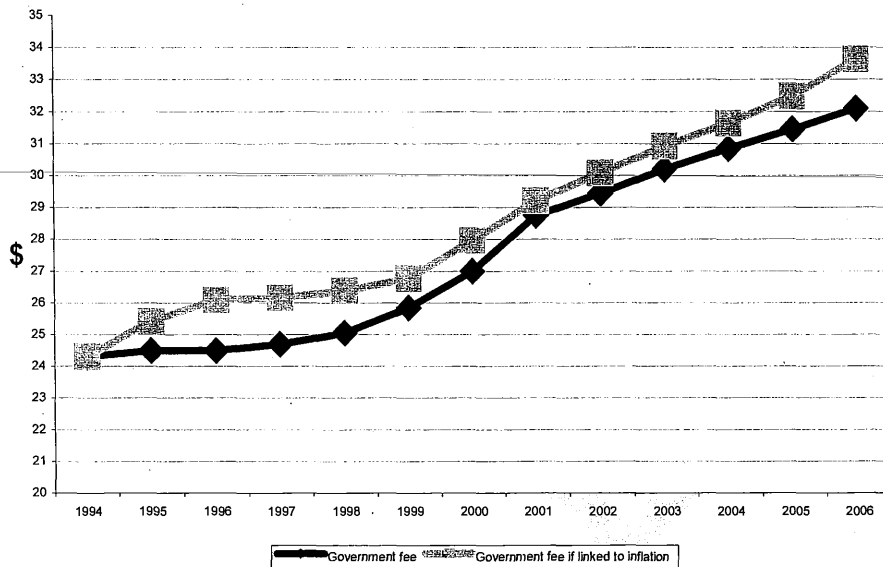
This figure of 80% declined rapidly over the next seven years (see figure 3), mainly because the amount the Australian Government decided to pay GPs per visit increased more slowly than inflation (see figure 4, which examines the MBS fee for the most common type of visit to a GP – item 23). In other words, if doctors kept doing the same thing each year, they went backwards financially. So some dropped or reduced their bulkbilling.

Since 2003/04, the Australian Government has introduced a number of incentives for GPs to bulkbill more people. The proportion of GP visits which are bulkbilled is rising again, but is still well below the 80% mark of a decade ago.

Figure 3: Proportion of GPs visits which are bulkbilled



**Figure 4: Medicare Benefits Schedule fee for the most common type of visit to a GP (item 23)**



Bulkbilling is not distributed evenly around the nation. It varies enormously, from 99% in some parts down to 47% in others. It is more common in areas where there are more doctors and more competition between doctors.

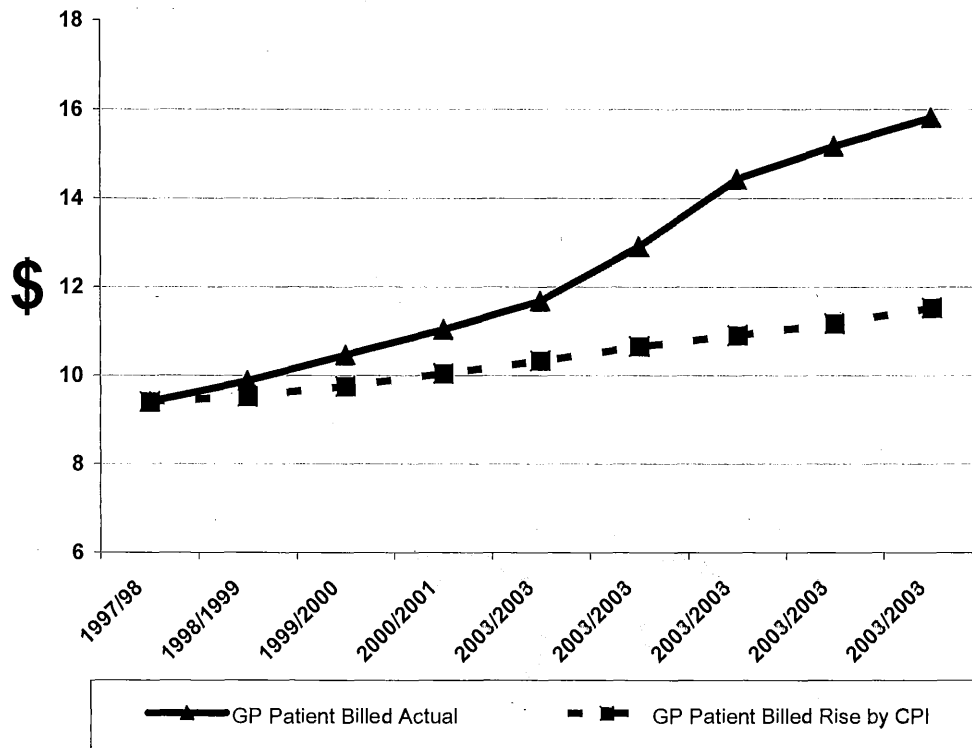
In most parts of Australia, bulkbilling is less common in rural and remote areas than in cities. When added to the relative scarcity of GPs this makes it even harder for some people in rural and remote regions of Australia to see a GP.  
 [MAP BELOW HAS BEEN DELETED]

And while bulkbilling rates are lower than 10 years ago, the out-of-pocket cost of visiting a GP, for people who are not bulkbilled, has risen. It was \$9.40 in 1997/98, and has jumped to \$15.82 in 2005/06 (see figure 5). This is higher than the cost would have been – \$11.53 – had prices simply kept pace with inflation.

The increase in out-of-pocket costs is due to a number of factors, including:

- the relative shortage of GPs (see figure 1), especially in some areas (see figure 2)
- the relative decline in the MBS schedule fee (see figure 4), which has left doctors going backwards financially and encouraged the decline in bulkbilling (figure 3).

**Figure 5: Out-of-pocket costs of a visit to the GP for non bulkbilled patients, compared with inflation**



## How often do we see GPs?

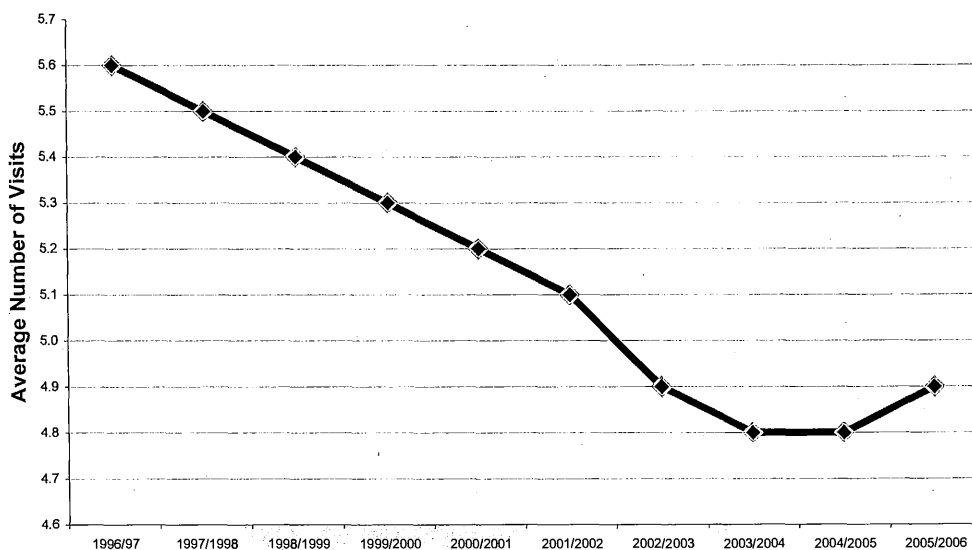
The number of visits to the GP per person has declined over the past 10 years. There is no evidence that the average person's interest in health care has declined, nor that we have less reason to see a GP, nor that GPs are being replaced by other health care practitioners for continuing health care.

Possible reasons to explain this decline include:

- the decline in the proportion of GP services which are bulk-billed (see figure 3)
- the rise in the out-of-pocket cost of seeing a GP (see figure 5)
- the relative decline in the number of GPs (see figure 1), which may lead to a difficulty in getting in to see a GP
- the availability of GPs for people in some areas (see figure 2)

- the decision by some GPs to work shorter hours, and to not provide home visits or after-hours services
- a decision to save up and visit a GP with several problems, rather than seeing a GP as each problem arises
- a decision to use emergency departments instead of GPs at times, partly for some of the above reasons.

Figure 6: Average number of visits to GPs per person per year



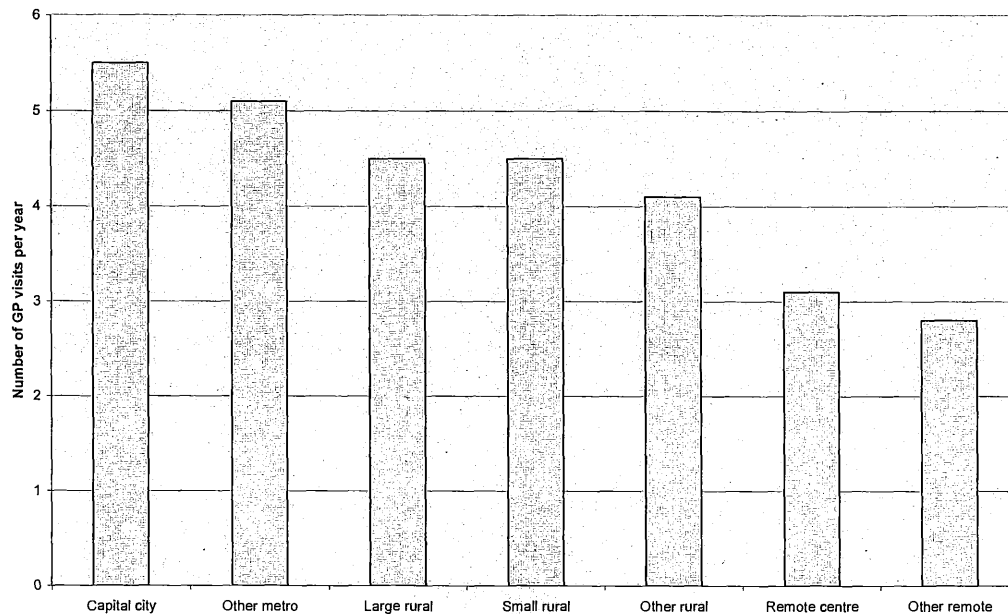
But it is also clear that people in cities see GPs far more often than people living in the country. In fact, figure 7 shows that the further you are from the city, the less often you see a GP.

Is this because people living in the country are healthier? No, in fact people living in the country are, in general, less healthy than people living in the city for a whole range of reasons. They often need more health care, not less.

The most likely reasons for people in rural areas seeing GPs less often are:

- there are fewer GPs in remote regions (see figure 2)
- GPs outside the city, with less competition from other GPs, are less likely to bulkbill, so the cost of seeing the GP is likely to be higher .

**Figure 7: Average number of visits to the GP per year by geographical location**



## What are we not being told?

There are many important questions which are not being answered by the Australian Government. They include the following.

- What is the average waiting time between making an appointment and seeing a GP for non-urgent care in different local government areas?
- How many GPs provide after hours care in different local government areas?
- What is the bulkbilling rate for people who do not have health care concession cards?
- What is the average bulkbilling rate for GPs in different local government areas?
- Which local government areas have no bulkbilling at all?
- What is the average number of visits to a GP in different local government areas?
- What are the average out-of-pocket expenses for people seeing GPs in different local government areas?

- Does the network of GPs throughout Australia provide fair access to health care for all Australians according to need?
- How common are mistakes in general practice?

Most of this information is already available to the Australian Government, but is not released.

## Summary

People find it harder to see a GP than 10 years ago. There are relatively fewer GPs, they work shorter hours and they are concentrated in major cities.

The cost of seeing a GP has risen over the past 10 years, as fewer GPs bulkbill and the Australian Government's schedule fees have not kept pace with inflation.

### 3: Specialists

Specialists are the second line of Australia's medical system. They see people for one-off consultations or procedures, and in some cases take over the long term care of people with complex conditions.

The Australian Government subsidises the cost of seeing a private specialist. It sets a fee for a visit to a private specialist, although the specialist does not have to stick to this amount. However the Medicare rebate is based on that set fee. Doctors can decide to accept the Medicare rebate as the full payment for their service – this is known as bulkbilling – or they can charge their own fee. Their patients then claim back some of the money they paid from Medicare.

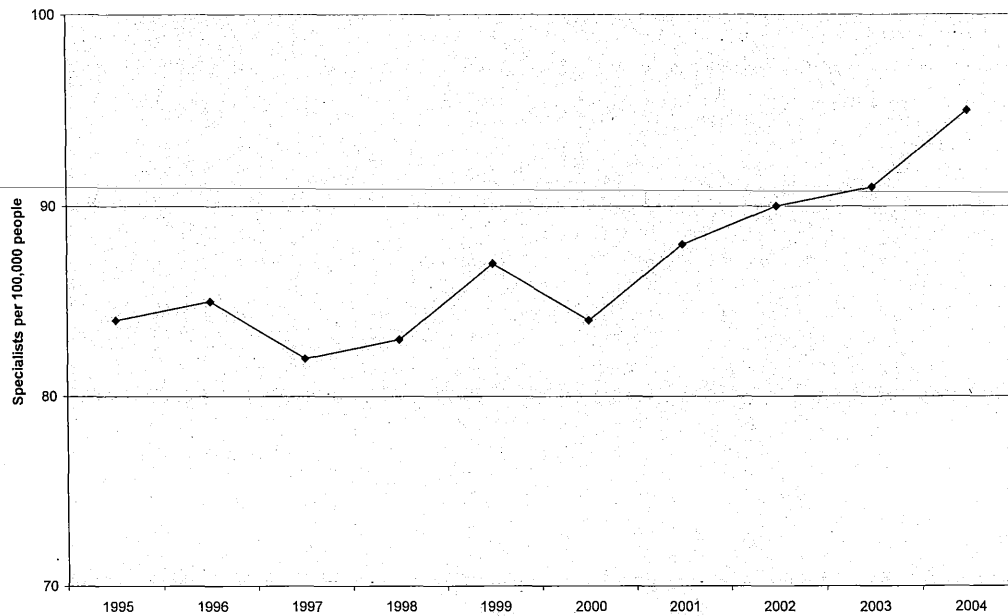
Following is a series of figures which lay out how many specialists there are in Australia, where they are, the extent of Government funding of their services and the extent to which individuals pay for their services.

Please note that these figures refer only to out-of-hospital visits to specialists. They do not refer to specialists working in hospitals, or to operations or other procedures in hospitals. We do not have adequate information on the fees charged by specialists working in private hospitals, nor on the out-of-pocket costs of seeing specialists working privately in public hospitals. The Australian Government has access to this information, but does not release it.

#### How many specialists are there?

In 2005 there were 23,600 specialist medical practitioners registered to work in Australia. That is a dramatic rise from the 16,000 specialists practising in 2000.

Figure 8: The number of specialists



## How often do we see specialists?

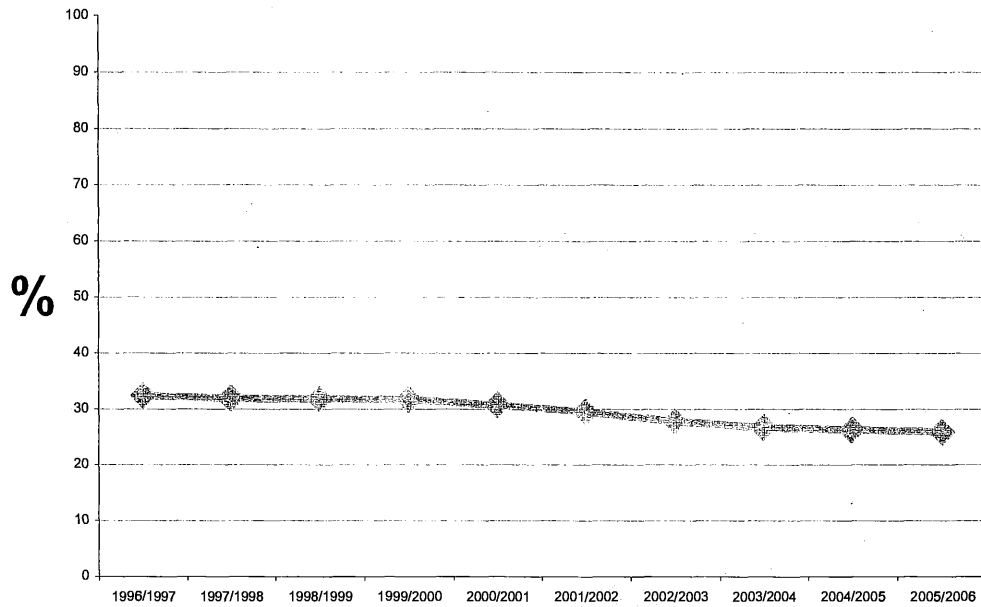
On average, Australians see a specialist (excluding pathologists and radiologists) once a year, and that has been the case for many years.

## How much do we pay specialists?

Schedule fees for specialists are much higher than schedule fees for GPs. Despite this, only 26% of visits to specialists (excluding pathologists and radiologists) are bulkbilled.

The figure of 26% is much lower than the proportion of consultations which are bulkbilled by GPs (75.6%), pathologists (85.7%) and diagnostic radiologists (60.2%). Figure 9 shows that the bulkbilling rate is low and declining further.

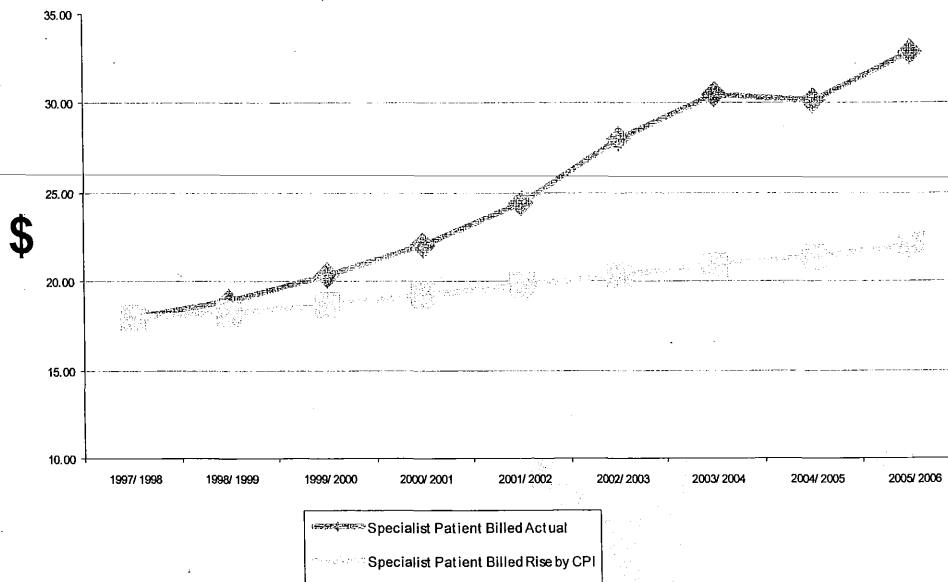
**Figure 9: Percentage of specialist visits which are bulkbilled\***



\* excludes pathologists and radiologists. Refers to out-of-hospital work.

The out-of-pocket cost of seeing a specialist, for people who are not bulk-billed, has risen from \$17.99 in 1996/97 to \$32.88 in 2005/06 (see figure 10). If the out-of-pocket costs had simply kept pace with inflation, the cost in 2005/06 would have been \$22.07.

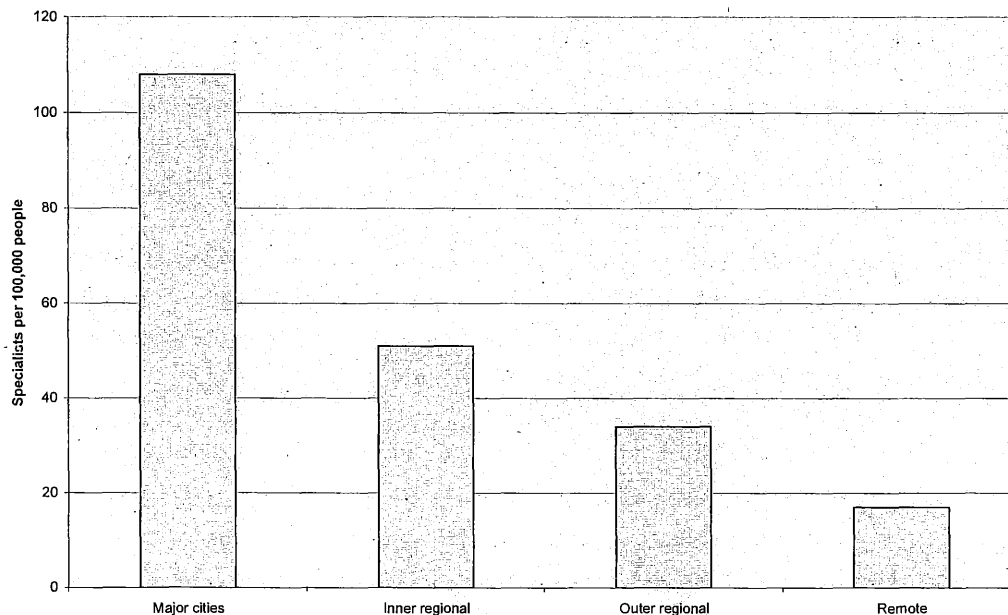
Figure 10: Average out-of-pocket costs of a visit to the specialist for non bulkbilled patients



### Where do specialists work?

Specialists work overwhelmingly in cities. There are six times as many specialists per person in the city as in remote regions. Even areas just outside cities have half the number of specialists as cities.

Figure 11: Specialists per 100,000 people by geographical region



## What are we not being told?

There are many important questions which are not being answered by the Australian Government. They include the following.

- What is the average waiting time between an appointment and a visit to a specialist for non-urgent care?
- Is this different for people in the city and people in rural and remote Australia?
- What are the average out-of-pocket costs for people having surgery?
- What are the average out-of-pocket costs for people seeing an anaesthetist in a hospital?
- What is the bulkbilling rate for specialists in different local government areas?
- What is the bulkbilling rate for different types of specialists?
- What is the average number of visits to specialists in different local government areas?
- What are the average out-of-pocket expenses for people seeing specialists in different local government areas?
- How common are mistakes by specialists?

## Summary

Specialists are highly concentrated in cities, and many rural people have difficulty seeing them.

The cost of seeing a specialist is rising. Bulk-billing rates for specialists working in the community are low and falling.

We have almost no information on the cost of private specialist services in hospitals. The Australian Government needs to release this information.

## 4: Public hospitals

Public hospitals provide essential care for the sick. They are fundamentally different from private hospitals. They provide:

- care to all, not only those who can pay for it
- free emergency care at all hours to all people who need it.

Public hospitals are funded by a combination of Australian Government money and money from the relevant state or territory government. Free access to public hospitals is a fundamental component of Medicare, and a continuing responsibility of the Australian Government.

Over the years, the proportion of public hospital costs paid by the Australian Government on one hand, and the states and territories on the other, has fluctuated. But that proportion has always hovered around a 50:50 share.

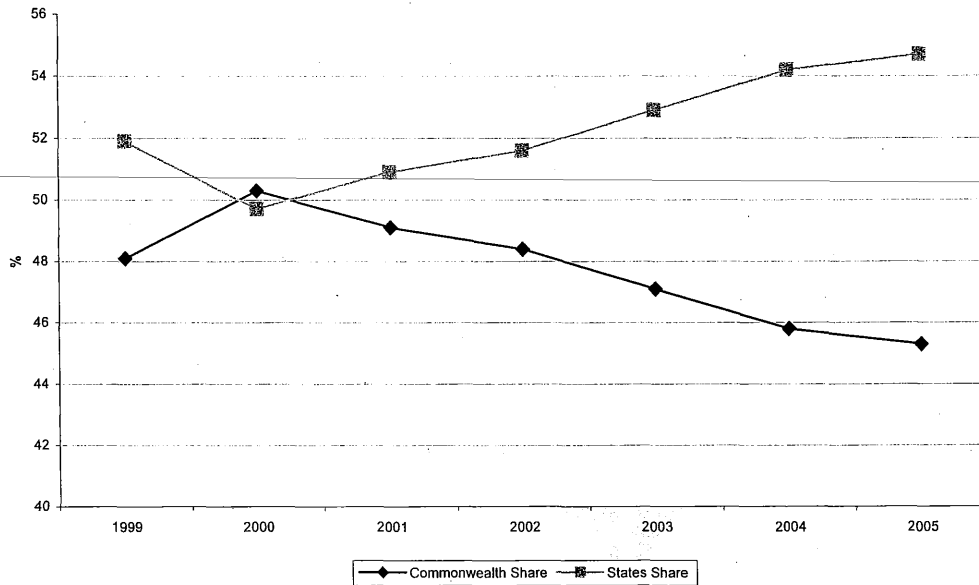
But since 2000, the Australian Government has gradually reduced its share of the funding of public hospitals (see figure 12). The states and territories are having to put in more and more.

In 2000, the Australian Government contributed 50% of the cost of running and maintaining public hospitals. In 2005, that share had dropped to 45%.

The states and territories have picked up the shortfall. Their share of funding of public hospitals has risen from 50% in 2000 to 55% in 2005.

If this trend continues, then in 20 years' time the Australian Government's share of public hospital funding will have declined to about 25%, and the states' and territories' share will have risen to about 75%. This would affect the states' and territories' ability to look after other essential services such as schools, police, public transport and roads.

Figure 12: Share of funding for public hospitals



In 1998 the Australian Government negotiated, with the states and territories, a new round of funding for public hospital services. There was a disagreement over figures used to adjust funding for annual price rises. The parties agreed to use an independent arbiter.

The arbiter recommended that, as prices in health care rise faster than inflation, the Australian Government's contribution to public hospital funding should be increased by 0.5% more than the inflation rate.

The Australian Government ignored that recommendation. It also ignored statements made by the Australian Institute of Health and Welfare, an expert body funded by the Australian Government, that health prices should be adjusted by a figure higher than the inflation rate.

Instead, the Australian Government has adjusted funding by a figure lower than the inflation rate. The result is that it has contributed far less to Australian public hospitals than the arbiter recommended, and than the Australian Institute of Health and Welfare would expect. That shortfall is now \$1.1 billion per year. Next year, the figure will be higher.

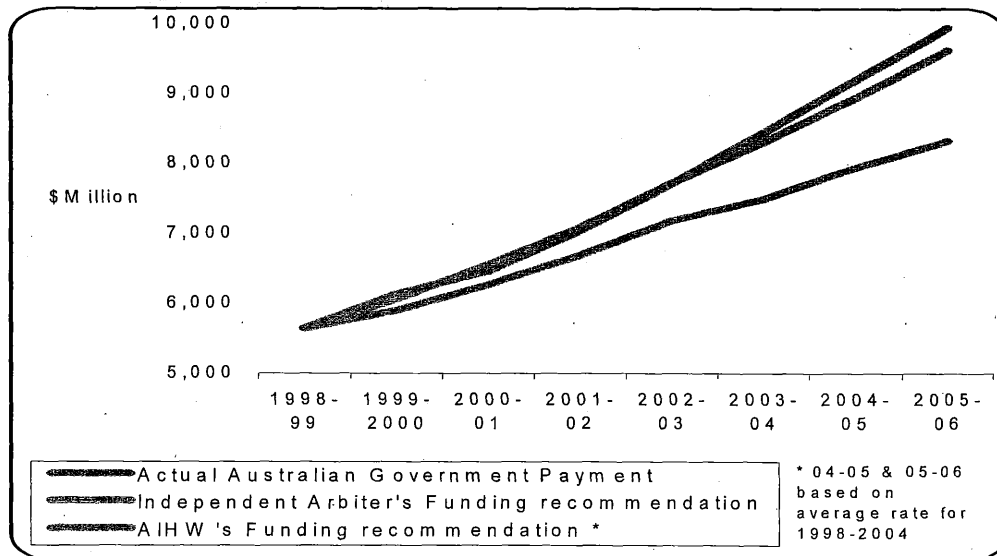
The Australian Government's contribution to public hospitals under the current funding agreement (which is different from the overall funding) has dropped to 39%. Under this agreement, which is up for renewal next year, the states and territories pay 61% of the costs of running public hospitals.

**Table 1: Public hospital cost-related funding increases versus private health fund premium increases (both set by the Australian Government)**

Year	Cost-related increase in public hospital funding (%)	Year	Cost-related increase in private health insurance fund premiums (%)
2002-03	4.33	2003	7.40
2003-04	3.40	2004	7.58
2004-05	3.40	2005	7.96
2005-06	3.20	2006	5.68
2006-07	3.30	2007	4.39

What could \$1.1 billion a year buy? About 350,000 admissions to public hospitals. That is quite a shortfall.

**Figure 13: Australian Government spending: actual versus recommended**



## Emergency work

Emergency admissions are an important measure of what a hospital does. People admitted through the emergency department are the sickest people. They need the most time, staff, technology and medicines to look after.

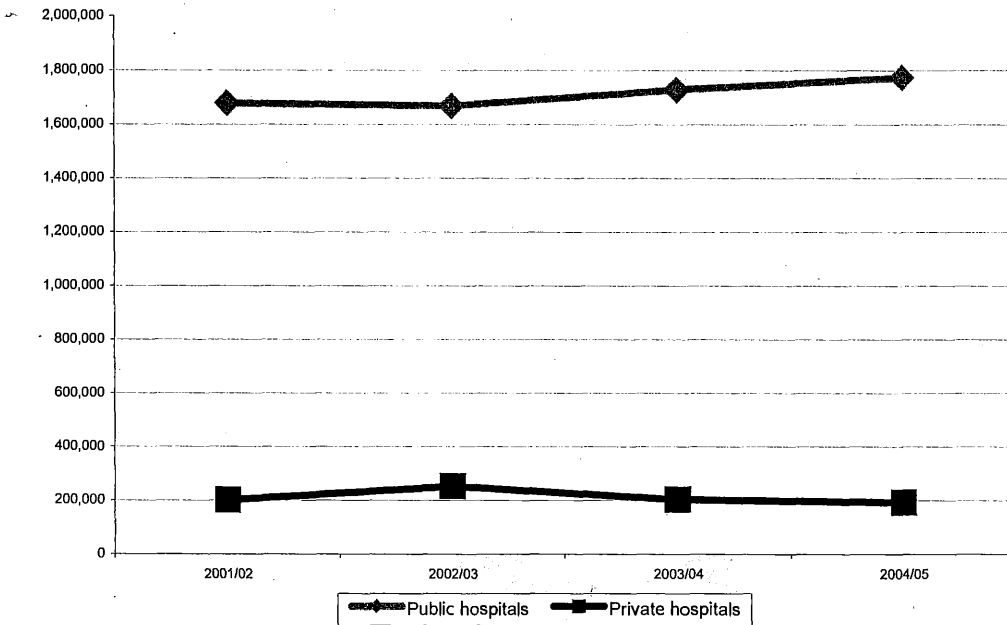
Figure 14 shows that by far the majority of emergency admissions are through public hospitals, not private hospitals. In fact, the number of emergency admissions in private hospitals is falling while the number of emergency admissions in public hospitals is rising.

This rise in public hospital emergency admissions is partly due to difficulties people have in seeing GPs which means they might not get the primary health care they need when they need it. Hospitals find people attending now are more likely to be seriously ill than they were 10 years ago.

And because emergency admissions take priority, sometimes public hospitals find it difficult to admit as many people for elective surgery as they would like.

It is worth adding that public hospitals are banned by the Australian Government from charging private health insurance funds for their members who access public hospital emergency departments (although private hospital emergency departments are allowed to charge).

Figure 14: Number of emergency admissions



## Older people in public hospitals

Older people tend to need more complex care, and more hospitalisation, than younger people. People over 65 account for about a third of total hospitalisations, and almost half of all hospital bed days.

In August 2006, there were about 2300 older people in public hospitals who should have been either home with community support or in an aged care facility. But the community support and the aged care places, which are largely the responsibility of the Australian Government to provide were not available.

This is a problem for both patients and hospitals. From the patients perspective, a busy hospital ward is not the best place to stay if they don't need to be there. And from the hospital's perspective, a bed used by someone who doesn't need it is a bed that is not available to someone who does.

- How many residential aged care or community-based support packages have been approved but are yet to be operational by local government area?
- What are the waiting times for older Australians once they have been assess as requiring residential aged care placement or community-based support package by local government?
- What is the true cost to the public health system of leaving older Australians waiting for a nursing home beds in a hospital each night?

### Summary

The Australian Government is paying a smaller and smaller share of public hospital funding each year. It is now paying about \$1.1 billion a year less than recommended.

If it paid the extra \$1.1 billion a year as recommended, public hospitals around the country could manage an extra 350,000 admissions a year.

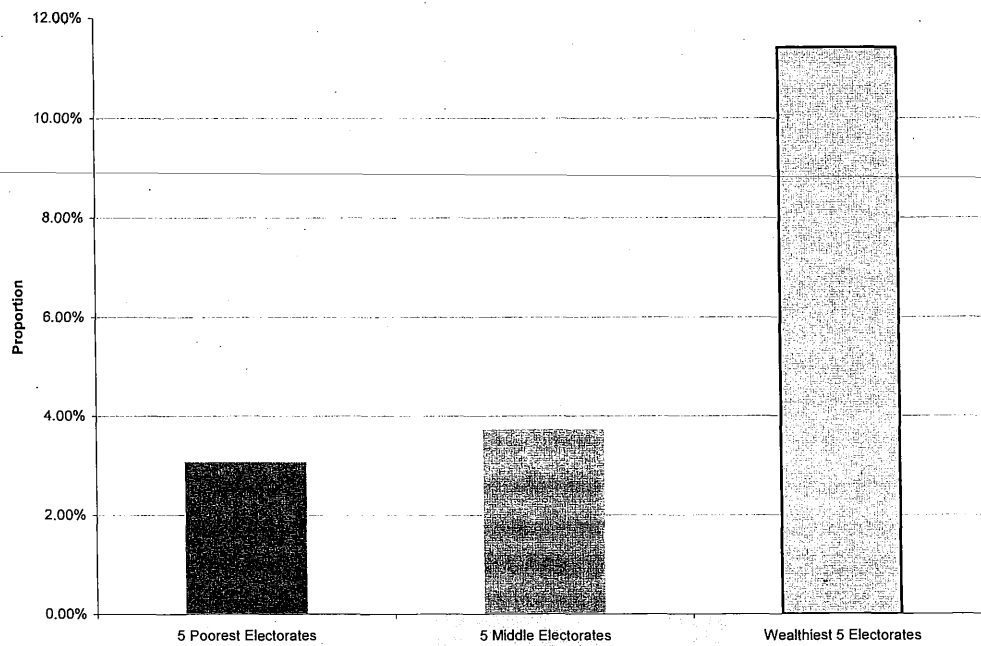
## 5: Medicare Safety Net

In 2004 the Australian Government introduced the Medicare Safety Net. Under the safety net, people get an 80% refund on their out-of-pocket medical expenses if they spend more than a certain amount in a year. In 2007 that figure is \$519.50 for people receiving Family Tax Assistance or who hold health care concession cards, and \$1,039 for other people. In other words, a person who is not a concession cardholder who spends more than \$1,039 from their own pocket will get back 80% of that extra money – the money over \$1,039.

What is the impact of the safety net? We can use the people of NSW – who received \$114 million in safety net payments in 2006 – as a case study.

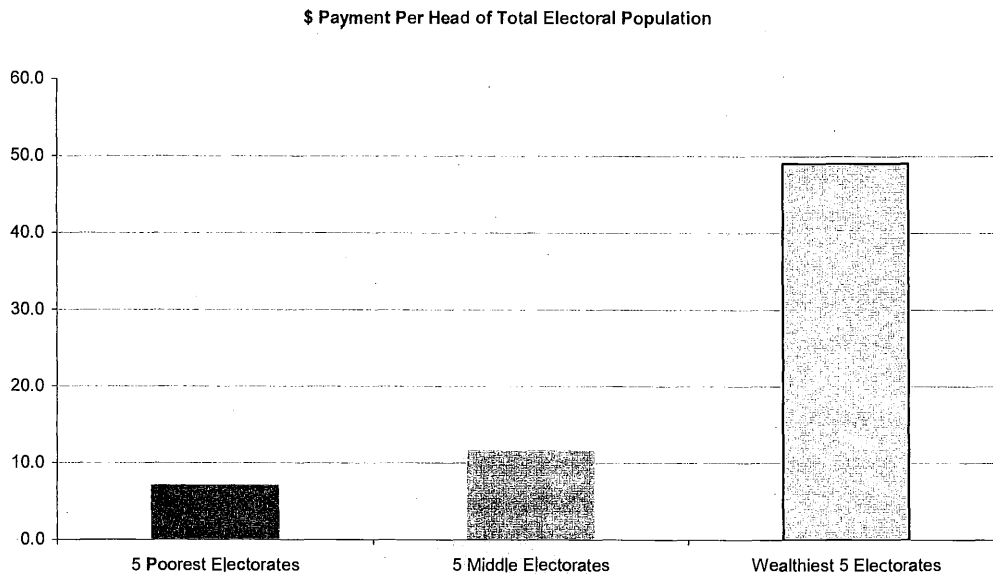
The case study shows that in NSW, people living in electorates with the lowest average incomes are far less likely to receive a safety net payment from the Australian Government than people living in electorates with the highest average incomes (see figure 15).

**Figure 15: Proportion of the population who received a safety net payment, by selected electorates**



And in NSW, people who live in electorates with the lowest average income receive far lower safety net payments from the Australian Government than people living in electorates with the highest average income (see figure 16).

Figure 16: Safety net payment per person (\$)



Finally, people living in inner Sydney receive three times as much in safety net payments as people living outside Sydney.

In effect, those most able to pay are more likely than those least able to pay to qualify for Medicare Safety Net payments, and they are likely to get far larger payments if they do qualify.

This maldistribution is worth noting because the safety net covers far more people than predicted – 850,000 last year, rather than the 450,000 originally stated.

There are a number of reasons for this maldistribution:

- the higher income you have, the more likely you are to spend money on health care and incur larger out-of-pocket expenses that are subsidised by the safety net
- there are procedures such as IVF which are covered only to a minimal extent by Medicare, but covered by the Medicare Safety Net. These are more likely to be used by those most able to pay.

There is another point worth noting. This scheme is complex, and difficult to understand.

There are two ways to claim Medicare rebates after seeing a doctor. One is to pay the account in full, then submit a claim form to Medicare. This method of payment, which is used more by people who have the cash to pay doctors' bills in full, counts towards the safety net.

The other way is to take the account, give it to Medicare, and have Medicare give you a cheque for the doctor, which you pass on and pay the gap. This method is favoured by people who don't have a lot of spare cash to pay doctors' bills. This method does not count towards the safety net, unless you then take the receipt from the doctor for your gap payment back to Medicare.

Yet again, the scheme has been set up to favour those most able to pay.

### Summary

The safety net payment scheme is complex, and favours those who can afford to pay doctors' fee in full.

Safety net payments go mainly to those most able to pay medical expenses. When those least able to afford medical expenses do receive safety net payments, they are far lower than average.

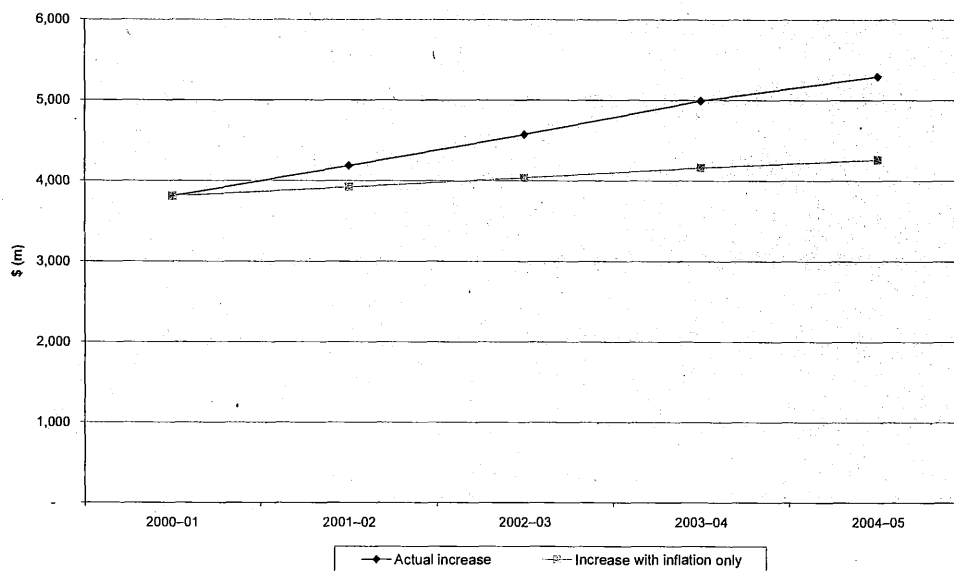
We do not know whether this is an aim of the Australian Government's policy, or merely a result of it.

## 6: Medicines

The Australian Government subsidises certain medicines through the Pharmaceutical Benefits Scheme (PBS). Other medicines are available through prescription, but are not subsidised by the PBS. Still other medicines, called over the counter medicines, are available from pharmacies and other outlets without prescription.

In 2005-06 the Australian Government paid more than \$6 billion in PBS subsidies. The cost of the PBS has been rising steadily for many years, and has been increasing faster than inflation (see figure 17).

Figure 17: Annual total spending by Commonwealth on PBS versus inflation



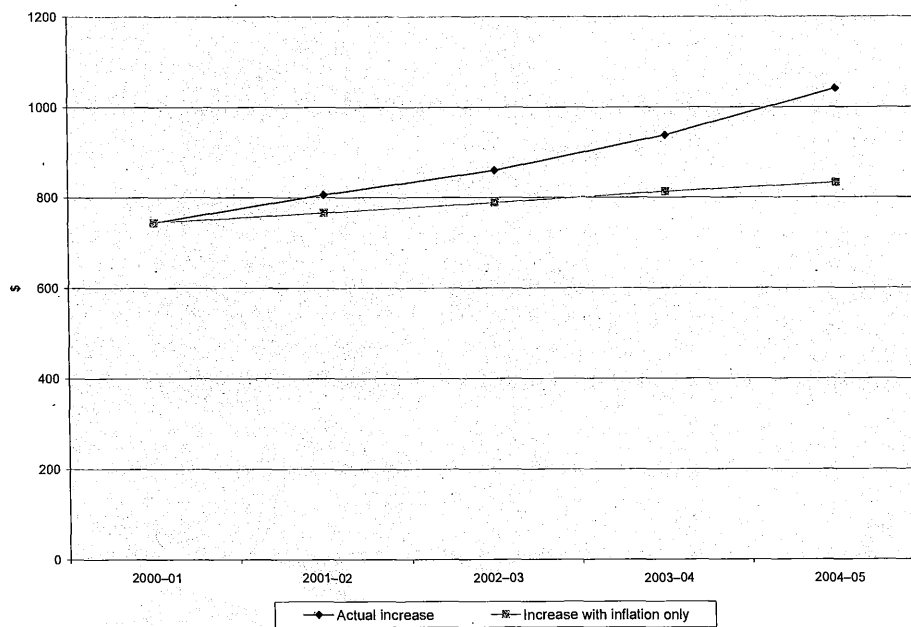
The reasons for this include:

- new drugs are, in general, far more expensive than existing ones
- doctors tend to prescribe new drugs instead of existing ones
- new drugs are being developed for conditions which had no drug treatment before

- the number of prescriptions written per person has increased gradually until the past year (see figure 20).

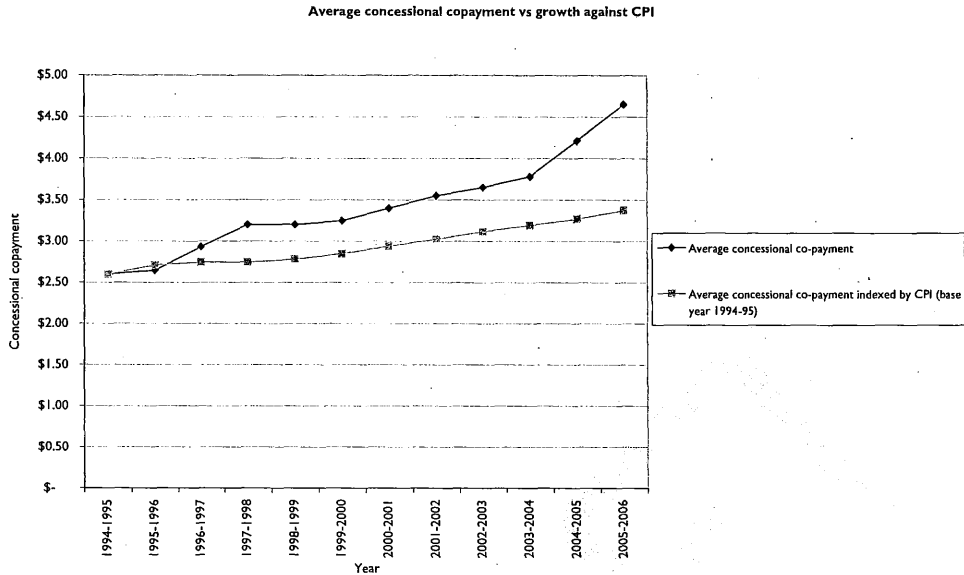
The costs for individuals are rising, too (see figure 18). The main reason for this is that the Australian Government has gradually increased the amount people are expected to pay per prescription (see figure 19).

**Figure 18: Annual total spending by individuals on PBS medicines**



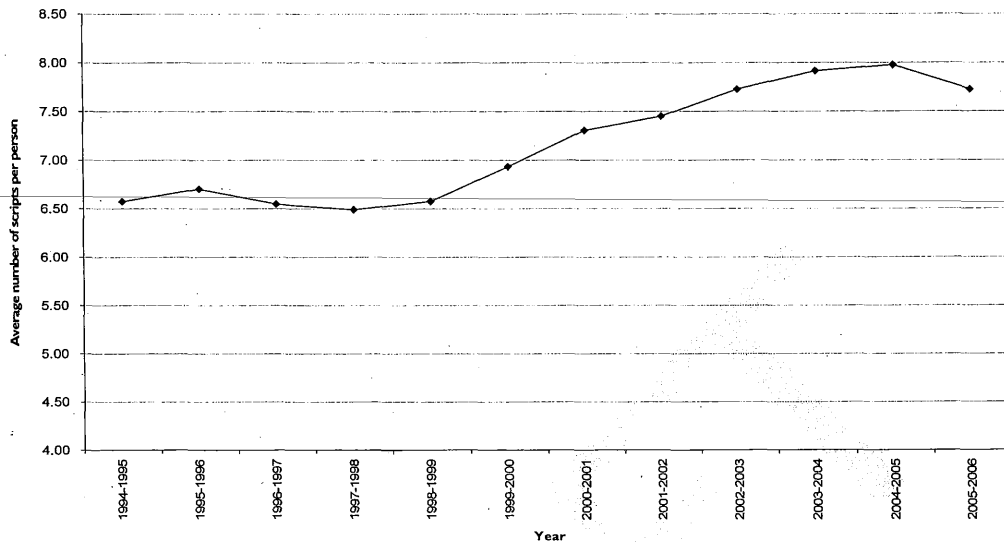
The Australian Government has gradually increased the payment made by people holding concession cards for each prescription. It cost \$2.60 to fill a script in 1994/95 – now it costs \$4.90. This rise is higher than inflation.

Figure 19: Average concessional payment per item versus inflation



This rise in out-of-pocket costs, which is similar to the rise for people who do not pay concessional prices for medicines, may have contributed to the recent decline in the number of scripts being filled at pharmacies (see figure 20). There may be other reasons as well.

Figure 20: Number of PBS prescriptions per person



## Summary

The cost of the Pharmaceutical Benefits Scheme accounts is rising rapidly for the Australian Government and for individuals. The rising costs are being shared.

State and territory governments fund medicines in public hospitals so they, too, are feeling the effects of price rises.

The number of scripts being filled has fallen in the past year. This may be due partly to the Australian Government's decision to increase out-of-pocket costs for people filling scripts.

## 7: Private health insurance

All Australians have health insurance. It's called Medicare, it's run by the Australian Government and it provides care in public hospitals and subsidies to those seeing doctors in the community, as well as a range of other health services.

Private health insurance is available outside the Medicare system. It covers part of the cost of medical expenses and accommodation in hospital for people who want to be treated as private patients. In some cases, and to varying degrees, private health insurance also covers part of the cost of seeing other health practitioners such as optometrists, dentists, physiotherapists and chiropractors. Some forms of health insurance also cover part of the costs of items such as cosmetic dentistry.

The Australian Government has made a number of changes to private health insurance over the past decade in an effort to improve the financial viability of the private health insurance funds, to increase the number of people with private health insurance, to curb the rapid rise in premiums, to support the private health sector and to take the pressure off public hospitals.

The first main change was the introduction of a 30% rebate on premiums paid to health insurance funds. That was introduced in January 1999. Minor adjustments have been made since.

The second change was the introduction of Lifetime Health Cover in July 2000. Lifetime Health Cover penalises people who join a private health insurance fund after the age of 30. It does this by adding 2% to the premium for each year of age over the age of 30. So a person joining a health fund at age 55 will pay 50% more than a person joining at age 30 (25 years extra x 2% equals 50% extra). Minor adjustments have been made since.

These changes have had the effect of enticing people to join a health insurance fund while younger, and deterring people in their 50s or older.

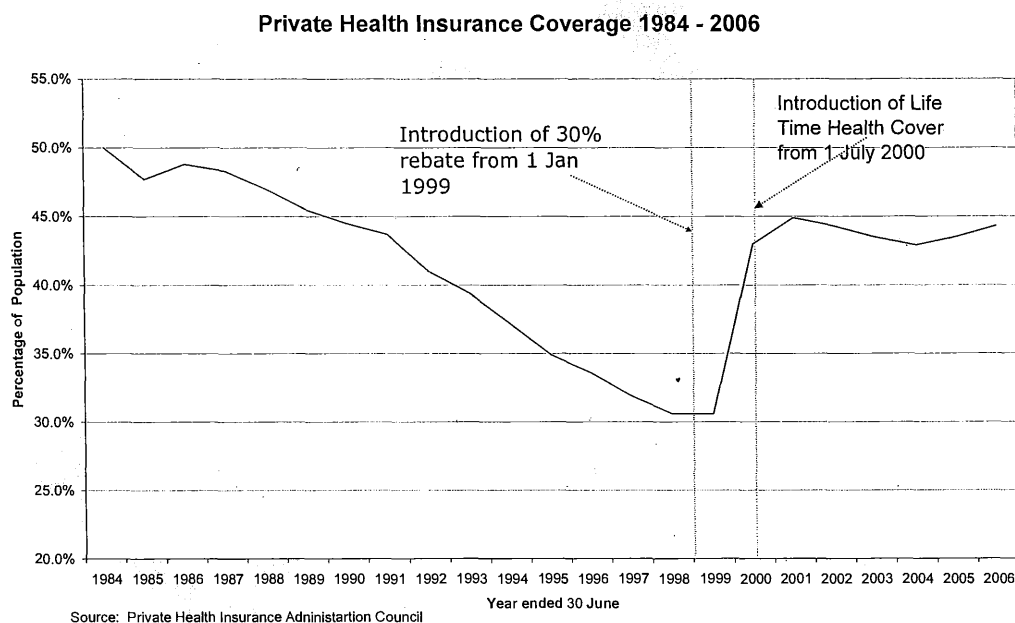
The Australian Government has also penalised people through the taxation system. People who earn more than \$50,000 a year, or couples earning more than \$100,000 a year, must join a health insurance fund or they will be forced to pay an extra 1% tax.

A number of questions must be asked of these policy changes, and of the private health insurance system as it stands.

## Has private health insurance coverage increased?

Yes, private health insurance coverage has increased, as seen in figure 21. It had been in a steady decline for some time, then jumped with the introduction of Lifetime Health Cover. Private health insurance coverage has declined a little then levelled since.

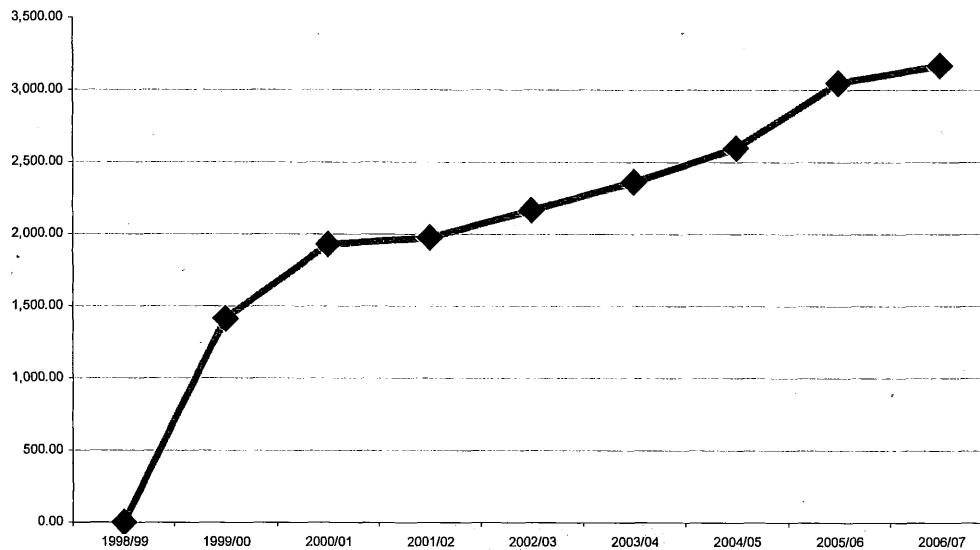
Figure 21: The percentage of the population with private health insurance



## How much does the rebate scheme cost taxpayers?

The rebate scheme costs taxpayers about \$3 billion in 2006/07. That is, taxpayers are chipping in more than \$250 each, on average, to support private health insurance funds. It is a figure which has grown rapidly since the scheme was introduced, and much faster than Australian Government predictions.

**Figure 22: Australian Government spending on the private health insurance rebate (\$ million)**



One of the aims of the rebate is to increase the number of people with private health insurance. But while the cost is increasing rapidly, the number of people in private health insurance funds is not.

In fact, between 2000/01, when the rebate scheme settled in, and 2005/06, which are the latest figures available, the amount the Australian Government spent on the rebate rose by 58% (from \$1.93 billion to \$3.05 billion). But the number of people in private health insurance funds rose by only 1.5% (from 8.7 million people to 8.8 million people).

### Have health insurance premiums stayed stable?

No. Health insurance premiums have continued to rise at roughly twice the rate of inflation.

In the last five years, health fund premiums have risen by an average of 6.6% per year. The average annual inflation rate during this period was less than 3%.

**Table 2: Health fund premium increase versus inflation**

<b>Year</b>	<b>Inflation rate (%)</b>	<b>Premium increase (%)</b>
2003	3.1	7.40
2004	2.4	7.58
2005	2.4	7.96
2006	3.2	5.68
2007	–	4.39

It is interesting to note that these premium increases are set by the Australian Government. The government justifies these higher premium increases by saying that prices in health care rise faster than prices in other areas. It seems unfair that the Australian Government does not apply the same reasoning to its share of the costs of public hospitals and bulkbilling payments under Medicare.

There is no benefit to consumers in these price rises.

### **Where does the \$3 billion a year extra for private health insurance end up?**

The \$3 billion a year spent on private health insurance premiums does not buy any health care directly.

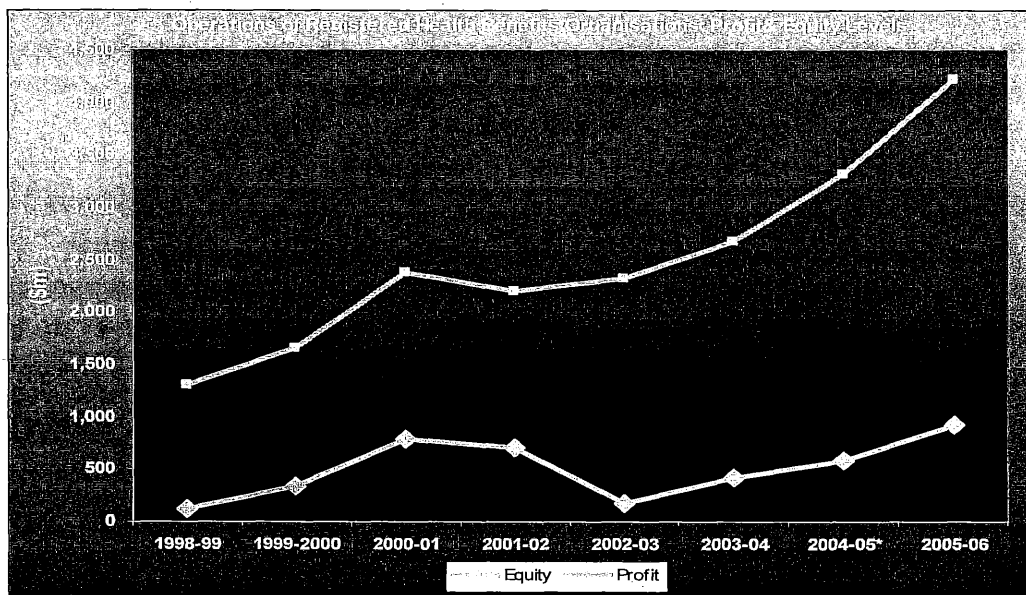
The funds now have more than \$4 billion in capital behind them (see figure 23).

Some goes on the increased management expenses of looking after the extra people with private health insurance.

The rest has gone, indirectly, towards increasing the number of people admitted to private hospitals for minor surgery.

Figure 14 shows it has not helped take the pressure of emergency admissions to public hospitals. Public hospitals still admit 61% of all patients, and do most of the caring for seriously ill people. Public hospitals still care for 95% of all emergency admissions.

Figure 23: Growth in equity and profits of private health insurance funds



## Summary

In the past eight years, private health insurance funds have increased their wealth by almost \$3 billion, while premiums have risen at roughly double the rate of inflation. Profits have risen dramatically

The private health system is not always complementary to the public health system – recent changes have made it more attractive to younger, wealthier and healthier people in preference to older people. It has not reduced the pressure on the public hospital system.

The private health insurance premium rebates cost more than \$3 billion last year. Some of the \$3 billion goes on management costs.

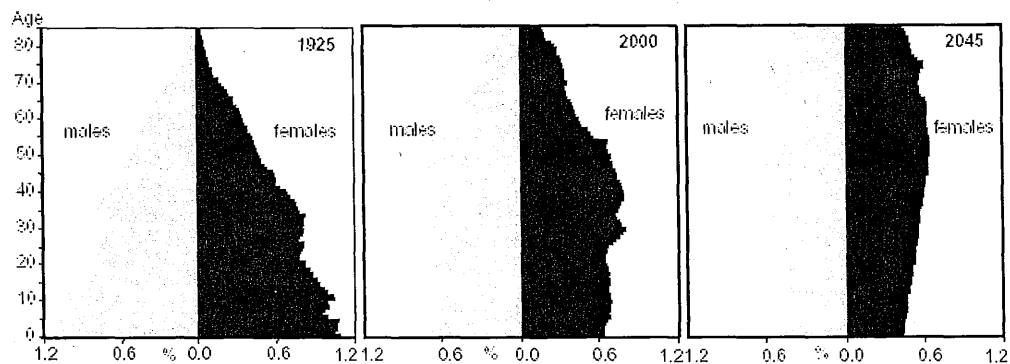
## 8: The future

Health systems across Australia, and throughout the developed world, are under pressure. The reasons are similar everywhere.

### The ageing population

Over the past four decades until very recently, fewer and fewer babies have been born each year. Over the same period, older people have been living longer. The result? Australia has shifted from a land of the young to one dominated by the middle-aged. And that shift will continue for decades to come.

Figure 24: Changing age structure of the Australian population, 1925-2045



There will be more older people, and they will use more health services. Also, the number of people of working age will decline.

So at the very time the demand for health services is increasing, the ability to supply the workforce is decreasing.

## **The workforce**

There are shortages of doctors, nurses and other health professionals throughout the world. In countries such as Australia, Canada, the UK and the US, 20-25 per cent of doctors are trained overseas.

The national workforce is growing at an annual rate of about 170,000 per year. But this will drop soon – it is predicted that in 2020, just 12,500 people will join the national workforce per year.

The health sector needs about 10,000 new workers a year just to maintain the status quo, and finding that number is a challenge. With the shrinking national workforce, it is inevitable that the number of people joining the national health workforce will shrink, too.

The workforce we have is also getting older. A large number of GPs and nurses will retire over the next 15 to 20 years, and will not be easy to replace.

The Australian Government is responsible for educating and training the majority of this workforce. Unless it increases numbers dramatically and develops new roles for new types of health workers, there will be significant staff shortages in the future. This will have a serious impact on the quality of care.

## **The changing nature of illness**

The nature of illness is changing. Once Australians suffered short-term diseases such as dysentery, but now the main causes of illness are long-term diseases like diabetes and cancer. Mental illness is also much more widely recognised and accepted, as are the associated illnesses and issues for families that go with it. Substance abuse, too, is being recognised as a health issue, not just an issue of law and order.

These changes are placing health services under significant and growing pressure. Half a century ago people went to their local hospitals for one-off treatment. They got better, or they didn't, but they didn't need to keep going in and out of hospital. And if people were elderly and clearly dying, there weren't the medications and technologies to keep them alive for long periods.

Now, people with a chronic illness may end up in hospital half a dozen times a year for the same condition. They can be treated and helped back on their feet. And people who are dying can be kept alive, often with a reasonably good quality of life, for weeks, months or even years with modern treatments.

Of course, much of this is a good thing. But it means that public hospitals are now dealing with older, sicker people, and they are dealing with them over and over again.

Public hospitals were not built to do that. If you were starting from scratch and designing a way to look after a person with diabetes, or heart failure, or recurrent anaemia, or even someone who was dying with dignity, you would not start with a hospital. You would start with providing health care in the community. Can the Australian Government help to build up community services to deal with the change in disease pattern?

## **A mismatch**

Although the health care system is evolving, it is still very reliant on the acute care hospital. While the hospital's role is important, and always will be, unless we put greater emphasis on preventive health and health promotion to reduce the risks and levels of chronic disease, hospitals will buckle under the weight of demand. They will end up able to provide emergency care only.

Doctors, nurses and other health professionals are coming to grips with the new world of health care. As students, they need access to appropriate, affordable, high quality education to take on new roles that reflect the needs of the current and future populations.

## **Rising costs**

Costs rise. That is the way of the world. But costs in health care are rising faster than inflation.

The cost of pharmaceuticals is rising (see chapter 6). The costs of technology are rising – new forms of testing and new treatments are usually more expensive than the ones they replace. And in some cases, the new tests and treatments are carried out as well as, not instead of, older tests and treatments.

The demands placed on the health sector are rising – people expect more of health services, and health professionals are doing more in order to meet those expectations.

One way the Australian Government has dealt with these rising costs is to shift some of them onto the individual. Ten years ago Australians spent the equivalent of \$9 billion from their own pockets on health care – now it's up to \$15 billion. The rate of growth is much higher than inflation.

### Summary

The costs of health care for the average person are rising rapidly. Overall, even after taking inflation into account, people are spending over 5% a year more on health care.

Health care is becoming more expensive, and more of it will be needed as the population grows and ages. The health system was designed for people with short-term illness, yet most of its time is spent looking after people with chronic, long-term illnesses. On top of this, the shortage of health professionals is likely to get worse.

Is the Australian Government doing enough to care for our health now and in the future?