



18 January 2017

The Hon Michael McCormack MP  
Minister for Small Business  
House of Representatives  
CANBERRA ACT 2600

Dear Minister

I write in response to your invitation for interested parties to make submissions regarding the formulation of the 2017-18 Budget.

Catholic Health Australia is the largest non-government provider grouping of health, aged care and community services in Australia, nationally representing Catholic health and aged care sponsors, systems, facilities and related organisations and services. Our services are provided in fulfilment of the mission of the Catholic Church to provide care for all who seek it.

I write on this occasion to urge the Australian Government to continue to take steps to create a sustainable aged care service industry based on consumer choice and control, as envisaged in the [Aged Care Roadmap](#) for the reform of aged care services.

The Roadmap was developed by the Aged Care Sector Committee, a representative body established by the Minister for Health and Aged Care to provide advice on care and support for older Australians. It draws heavily on the Productivity Commission's 2011 report *Caring for Older Australians*. Simply put, the Roadmap envisages an integrated residential and home care aged care system based on:

- a single independent care needs and means assessment process across all aged care to determine each consumer's eligibility for aged care services and financial assistance, and
- consumer choice of provider and control over how the financial assistance is used, including where each consumer chooses to live while receiving care.

At its core, to operate effectively, a more market-based system such as this requires the phased removal of the current regulations that control the volume, type and allocation of aged care services.

We acknowledge that recent governments, including the current government, have already initiated reforms which will contribute to the achievement of the Roadmap destinations. We also acknowledge that the Parliament has legislated for an independent Review of these reforms. The Review's report, which is required to be tabled in Parliament in August 2017, will help inform the next stages of reform, including measures to ensure their affordability.

However, there are two important reforms that can be signalled in the 2017-18 Budget that are critical preparatory measures for achieving a system based on consumer choice and control and which would not pre-empt the legislated Review. These measures are:

- to improve consumer access to home care packages that align with their assessed needs, and
- to ramp-up the release of home care packages consistent with existing policy.

A major focus of reforms to date has been increasing the opportunity for older people to choose to receive care in their own homes with the assistance of aged care packages. As well as responding to consumer preferences, providing more aged care in people's own homes is also cost-effective for the government and the taxpayer. However, the opportunity to receive care in the home is compromised currently because the number of packages is controlled at each of four funding levels and the number of places at each funding level does not align with the spread of consumer assessed needs. Hence many consumers prioritised by MyAgedCare are not able to access the funding level that matches their care needs.

In order to address this inflexibility, we urge the Government to announce in the 2017-18 Budget its intention no longer to control the number of packages by funding level, but instead assign packages to individuals as prioritised by MyAgedCare. The budget control would instead be an annual cap on funding equivalent to that which would otherwise have resulted under the government commitment to increase the ratio for home care packages to 45 operational places per 1,000 people aged 70 and over by 2021-22.

A related issue that should be taken up in the 2017-18 Budget is to step up the release of home care packages, consistent with policy announced in the 2012-13 Budget to increase the overall target provision ratio to 125 operational aged care places per 1,000 people aged 70 and over by 2021-22, including, as noted above, a significant rebalancing to home care by increasing the target ratio for home care packages to 45.

It is disappointing that since 30 June 2011, the operational provision ratio for home care packages has increased by only 4.9 to 31.9, well below the target ratio of 45, and the overall operational provision ratio has increased by only 0.4 (from 112.8 at 30 June 2011 to 113.2 at 30 June 2016).

Taking steps to ensure that the target ratios are achieved is not only important as a means of increasing the availability of services to meet consumer needs, but also as a means of assessing the extent of unmet need as the current rationing of services is relaxed. It will also provide more information about consumer preference between home care and residential care which, together with a better understanding of unmet need, will inform decision making about the affordability of an uncapped supply system driven by consumer choice and control and by a more effective eligibility gateway provided through MyAgedCare.

In this regard, it is worth recalling that a phased relaxation of controls on the supply of aged care places and a rebalancing of places in favour of home care was a key strategy of the 2012-13 Budget aged care reforms to help transition from a highly regulated system to one based on consumer choice and control, and for establishing the affordability of uncapping the supply of aged care places.

To sum up, we urge the Government in the 2017-18 Budget to ramp-up the release of home care packages consistent with existing policy, and to increase consumer access to aged care packages that suit their assessed needs by removing the control of package numbers at each of the four funding levels. In due course, the objective should be to introduce a system comparable to residential care where financial assistance for individuals depends on their assessed needs, and access is not controlled at each funding level.

Thank you for giving consideration to our submission. If you or your staff would wish to discuss the matters we have raised, please contact our Director of Aged Care, Nick Mersiades, at [nickm@cha.org.au](mailto:nickm@cha.org.au) or on 0417 689 626.

I am copying this letter to the Minister for Aged Care, the Minister for Health, the Minister for Finance, David Tune and Margot McCarthy, Deputy Secretary of the Department of Health.

Yours sincerely,



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Chief Executive Officer



CATHOLIC  
HEALTH  
AUSTRALIA

PRE-BUDGET  
SUBMISSION  
2017-18



CATHOLIC HEALTH  
Australia

# Catholic Health Australia's Health and Aged-Care

## Pre-Budget Submission 2017-18 January 2017

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

### There are on-going challenges for our health system:

Although Australians generally enjoy good health by comparison with most other countries, there are many groups that are still missing out. They include people whose circumstances and background make it more likely that they will disproportionately suffer from ill health than those in society at large, as well as those who find it hard to access necessary health services.

People who suffer a disproportionate share of poor health outcomes and are not served well by the current configuration of the health system include:

- Indigenous Australians;
- people living in certain geographic areas including regional, rural, remote and outer suburban locations;
- those who are financially less well off;
- those who suffer from mental illness;
- those who suffer from dental health problems;
- those living with varying degrees of intellectual and physical disability and ill-health (including carers).

In addition to the specifically identified groups above, Australians as a whole are suffering from an ever-increasing burden of chronic disease. Many are dealing with multiple chronic conditions simultaneously. This trend is set to accelerate into the future due to factors such as lifestyle and the ageing profile of the population. Type II diabetes, for example, is expected to become the leading cause of disease burden by 2023, (AIHW)<sup>1</sup>.

CHA believes that the Australian health policy decision makers need to concentrate on making improvements to our current health system in order to address these persistent challenges. Some strategies for policy decision-makers are outlined in this submission.

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

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<sup>1</sup> AIHW. analysis of ABS. 2013a.

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## How we can strengthen primary and community care?

Good policy in this area is about providing resources to primary care providers and autonomy to local governance of health services – with accountability based on health outcomes. It is about encouraging partnerships and collaborations between service providers from across the care continuum. Local autonomy will also enable health services to link closely to and be aligned with the provision of other local services including social services, housing, transport and education.

Local autonomy is important because the circumstances and needs of communities and individuals vary widely across and between regions. There can be large variations in health status and environment across relatively small areas. Health services need to be responsive to local circumstances and be able to determine the mix of services that are provided, as well as the way in which they are delivered.

Good policy is not about being prescriptive or trying to fit a “one size fits all” approach to organisations that will necessarily evolve quite different ways of addressing local health needs depending on local circumstances. Some areas where CHA believe further work still needs to be done are detailed below.

### Build the capacity of Primary Health Networks to provide support to primary care providers in their regions

As the demand for primary care increases due to factors such as the increasing incidence of people with multiple chronic conditions, ageing of the population and shorter hospital stays, primary care providers will need additional support to ensure consumers have continued access to necessary care in an increasingly complex environment.

Primary Health Networks (PHNs) have been developed to assist primary care providers in linking and co-ordinating with other primary care and support services in the region, assist with prevention and early intervention initiatives as well as supporting integration and multidisciplinary care. They also have a role to play in providing an increased focus on population health and better management of chronic disease.

In 2016, PHNs were given responsibility for commissioning a number of services including the National Disability Insurance Scheme (NDIS), service delivery arrangements for mental health and suicide prevention services including coordination of mental health stepped-care. Given the scope and the breadth of tasks PHNs have been commissioned with, it is critical that PHNs be given policy and funding stability in order to evaluate and achieve positive outcomes.

### Care co-ordination for chronic disease management

Increasing numbers of Australians are living with one or more chronic conditions; many have multiple conditions. The complexity and fragmentation of Australia’s health system often makes it very difficult for patients to access the care and support that they need – even if it is available.

Often people with multiple co-morbidities will also need to access services from other human service streams including, for example, housing, employment, mental health and/or residential aged care. A failure to appropriately access these other services, for example supportive accommodation, may in turn lead to a deterioration in a person’s health status.

CHA therefore urges that all PHNs be funded on a risk-adjusted population basis to provide care co-ordinators whose function will be to help those with high and complex care needs navigate their way through the health, welfare, housing, employment and aged care systems as appropriate. We would see this as primarily a social worker role, with the providers most likely located in, or working very closely with, primary care providers. We are aware that some PHNs are already operating on this basis and recommend that program outcomes are evaluated closely.

The scheduled Health Care Homes trial (due to begin in July) is welcomed and CHA encourages the Government to address doctors' concerns regarding the level of reimbursement suggested as caring for chronically ill patients requires a significant investment in time. For this trial to be a success, a robust evaluation must be undertaken in tandem with developing a culture of continuous quality improvement.

### Increased focus on preventative health and health promotion

CHA recognises the admirable work done in Australia to reduce tobacco consumption and protecting against skin cancer. The success of these prevention initiatives needs to also be repeated in other areas of concern.

Alcohol is still a significant cause of death and hospitalisation and much work still needs to be done in reducing binge drinking and encouraging low to moderate levels of consumption. Some strategies could include regulation of physical availability (especially late-night venues where binge drinking is a risk); taxation and pricing measures to discourage excessive consumption (particularly at a low price end of the market); treatment and early intervention; well-funded, sustained public education to reduce the glamour of excess alcohol consumption and continue to work towards reducing alcohol consumption in Indigenous and other disadvantaged communities.

Healthy eating must be encouraged in order to reduce the excessive consumption of salt, fat and sugar. Options available to policy decision-makers include using taxation and pricing measures to provide greater financial incentives to consume fresh food and less processed food with high levels of salt, fat and sugar content (including subsidies for rural and remote area transport of fresh foods, and tax and regulatory restrictions on less healthy food); restrictions on advertising and promotion of unhealthy foods to children; continued public health and marketing campaigns on healthy eating; expand the supply and access to the relevant allied health workforce professionals and work with indigenous communities to encourage healthy eating patterns.

Although Australia is a sporting nation, regular participation in exercise and activity is essential. This could be achieved by an increase in community education and marketing; consideration of targeted financial support to enable financially disadvantaged people to participate in structured exercise opportunities; working with state and local governments to ensure that planning and transport policies encourage increased physical activity.

Particular care and attention needs to be given to the development of strategies for more disadvantaged groups. While the incidence of lifestyle-related chronic disease is higher than for the rest of the community, vulnerable and disadvantaged people are also more susceptible to the negative impact of tax and price increases. Interventions using these tools need to be designed in such a way that does not inadvertently drive people further into poverty and we need to be sure that the benefit of an intervention outweighs any potential harm.

We note that tax and price signals can also include price reductions for healthy options such as subsidies for fresh food and its transport, as well as price increases for more harmful products.

## The health system would benefit enormously with improved integration

Integrated care is more likely to be achieved where there is a strong alignment of financial, administrative, operational and clinical objectives, so good policy will be any measure that assists in achieving this.

A well-integrated system would aim to deliver good patient experiences, good outcomes and cost-effective care and would be measured on the basis of outcomes, rather than process and compliance with standards.

The Catholic health sector can serve as an example of how a more integrated system could look. Many catholic hospitals are undertaking projects to develop new models of care for patients with chronic disease conditions. They are also partnering with other health care stakeholders such as PHNs and health insurers to find better solutions to the changing burden of disease in our population. Hospitals and their clinicians know that patients with complex chronic disease complications need an integrated health system to maximise patient outcomes. Too often, at present, patients can be lost between systems and knowledge transfer is lost.

Catholic health services run both public and private hospitals – and can see how the strengths of both can complement each other to deliver a more effective system. With private hospitals providing 40 per cent of hospital admissions and over 65 per cent of surgery, we should be talking more about “Australia’s hospital network” rather than referring to public or private hospitals in isolation.

### Expanding sub-acute care

CHA believes that there should be a greater investment in sub-acute care. Too many people remain in hospital who should be being treated in a more appropriate setting, and there are those who have been discharged to the community who would benefit from a more stepped-down approach prior to going home.

Unfortunately, the funding of many sub-acute services has suffered from being located near the boundaries of Commonwealth and state/territory funding responsibilities. Sub-acute services have also struggled to attract private health insurance funding for patients using their private health insurance to fund an episode of care.

CHA calls upon the states and territories to provide the LHNs or their equivalents with the scope and resources to fund additional sub-acute facilities and services; and equally calls upon private health insurers to adequately fund sub-acute care for privately insured patients.

### Improve access to palliative care

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

CHA believes that access to high-quality palliative care at the end of life should not depend on where you live or how you have most recently engaged with the health system (i.e. as a public or private patient. Patients who access palliative care following an admission as a private patient face a range of costs for their ongoing care that would not have been incurred had they been a public patient).



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

CHA also calls on private health insurers to adequately fund palliative care for privately insured patients. One solution, as suggested in the 2015 Productivity Commission report<sup>2</sup> is to facilitate trials of expansions— informed by proposals from insurers — and evaluate these trials.

### Continue to examine the contribution of private health insurance (PHI)

Private health insurance is the major funder of private hospitals, which provide 40 per cent of Australia's hospital admissions and two-thirds of elective surgery. PHI also provides funding of over \$1 billion<sup>3</sup> for treatment of private patients in public hospitals.

Given the key role that private health insurance plays in supporting private hospitals – and, by extension, public hospitals – it is timely to consider how it best fits in with the rest of the health system.

CHA strongly supports the review underway into the role of PHI, coverage and operation of PHI arrangements.

Another area of potential policy development is whether private health insurance could have a role to play in assisting to finance aged care given the most recent Inter-Generational Report showed that aged care funding was set to more than double as a proportion of GDP from 0.8 per cent to 1.8 per cent by 2050<sup>4</sup>.

### Redesign of the health workforce

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.

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.

Despite the increase in medical and nursing graduates there is still significant geographical maldistribution of health professionals. Various models of health workforce innovation have been introduced internationally with success and could easily be implemented here in Australia.

As the delivery of health services increasingly relies on members of multi-disciplinary teams working together, CHA calls on universities and training providers to better integrate courses for health professionals across discipline boundaries for non-discipline-specific subjects. For

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<sup>2</sup> Productivity Commission 2015, Efficiency in Health, Commission Research Paper, Canberra.

<sup>3</sup> AIHW 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW.

<sup>4</sup> 2015 Intergenerational Report Australia in 2055, March 2015

example, creating a National Framework for Indigenous Health Practitioners (Workers)<sup>5</sup> would create more training incentives to upskill in a local context and is considered essential to sustain particularly remote community controlled health care services.

CHA also supports the non-government sector playing an increasing role in health professional training and we support the development of activity-based funding currently being undertaken at the Independent Hospital Pricing Authority (IHPA)<sup>6</sup> for clinical placements with non-government health providers. The Australian Private Hospitals Association and CHA have also prepared a report measuring the investment into education and training in the private hospital sector<sup>7</sup>.

## Reform health system governance

CHA proposes that there are several options, either of which, would create a more cohesive and less fragmented governance and accountability framework. Some examples include creating a single tier of government funder for publicly funded health services by establishing regional health authorities; or 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.

CHA strongly encourages the Government to continue to work on ways to improve the relationship between the states and the Commonwealth so that quality health services can be delivered efficiently. The future sustainability of public hospitals depends on the Commonwealth to renegotiate public hospital funding arrangements with adequate long-term funding to guarantee that healthcare will continue to be accessible (particularly for low-income Australians) now and into the future.

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

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<sup>5</sup> National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016 - 2023)

<sup>6</sup> Independent Hospital Pricing Authority (IHPA) Teaching, Training and Research costing study July 2016

<sup>7</sup> Education and Training in the Private Hospital Sector, 2015 survey results, APHA & CHA 2017

## How can better consumer engagement and empowerment be facilitated?

Effective policy in this area would place consumers and consumer interests at the core of all decision-making in relation to the resourcing and delivery of health services. Good policy would also ensure that consumers had the tools, resources and the process opportunities to be fully engaged and empowered.

### Provision of performance information for consumers

CHA believes that a consumer-driven health system requires consumers to have an informed knowledge of the performance of providers. Performance reporting can be a powerful tool that: enables consumers to make informed choices when selecting a provider of health services (where such services exist); acts as a powerful incentive for all providers to lift their standards to the level of the best performance and provides strong accountability for the community at large, including funders, as to the performance of providers.

CHA believes this could be done through the progressive augmentation of the MyHospitals website with more detailed provider performance information including hospitals and clinicians – both medical as well as allied health providers.

### Improved health literacy

Health literacy is a fundamental part of preventive health and importantly is also a critical part of disease self-management for consumers in the event of ill health.

The level of community knowledge about health and well-being, including knowledge of infection control and hygiene (including the importance of hand washing and food hygiene) and lifestyle issues (including knowledge of healthy diet and exercise requirements) has an important influence on overall population health outcomes. In that respect health literacy can be seen as one of the social determinants of health.

Health literacy is also about more than just being able to comprehend advice from a health practitioner about the clinical aspects of a health condition. It is also about consumers having the ability to apply that information in a meaningful way. As one example, there may be cultural or socioeconomic factors at work that act as barriers to being able to implement the advice from a health practitioner.

A health-literate community involves strong partnerships, communication and collaboration between consumers, carers and community as well as health practitioners and the wider society.

CHA proposes that health literacy, in common with the other social determinants of health, needs to be incorporated into the programs and policies of all other areas of policy – particularly within the health system but also within the education and welfare systems.

Choosing Wisely began in the United States in 2002<sup>8</sup> with the publication of 'Medical Professionalism in the New Millennium: A Physician Charter' by the American Board of Internal Medicine (ABIM) Foundation, the American College of Physicians Foundation and the European Federation of Internal Medicine. The charter provided a new set of professional responsibilities

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<sup>8</sup> <http://www.choosingwisely.org/about-us/>

for medical practice. Among the commitments set out were: 'managing conflicts of interest, improving the quality of care, improving access to care, and promoting the just distribution of finite resources'.

In 2014, Choosing Wisely Australia<sup>9</sup> was launched. It aims to bring the medical community together to improve the quality of healthcare through considering tests, treatments, and procedures where evidence shows they provide no benefit or, in some cases, lead to harm. As the catalyst for public discussion, Choosing Wisely Australia is encouraging clinicians and consumers to start a conversation about what care is truly needed — identifying which practices are helpful and which are not. A cross-section of medical colleges and societies have come together to identify practices that warrant scrutiny, examining the evidence and drawing on the expert opinion of their members to develop a list of recommendations: "Tests, treatments and procedures to question". The sharing of information among peers is a key to reducing these problematic practices that have become ingrained in the system. Importantly, it sets the scene for wider community involvement. CHA strongly supports this initiative.

### 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.

Compared to the OECD average, Australia has a high proportion of health expenditure that is funded by individuals. In 2015, according to the OECD<sup>10</sup>, individuals' out-of-pocket expenses contributed 20 per cent of health expenditure in Australia compared to only 10 per cent in the UK and 13% in New Zealand.. The share of health expenditure made up by out-of-pocket costs increased in Australia by 1% between 2008 and 2012.

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 where bulk billing general practices are scarce will be subject to out-of-pocket charges – and ultimately reliance on the safety net – that people living in other geographic regions do not face. The current government's decision to freeze indexation of Medicare rebates for four years from 1 July 2014 until July 2018 will only serve to increase the out-of-pocket charges for those that cannot afford it as GP practices become unsustainable.

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-concessional fees and prices notwithstanding their clear clinical need.

CHA recommends that a review should be undertaken from the perspective of consumers rather than funders – 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.

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<sup>9</sup> <http://www.choosingwisely.org.au/home>

<sup>10</sup> [www.oecd.org/australia/Health-at-a-Glance-2015-Key-Findings-AUSTRALIA.pdf](http://www.oecd.org/australia/Health-at-a-Glance-2015-Key-Findings-AUSTRALIA.pdf)

## Universal dental insurance

CHA supports the concept of a national insurance scheme for dental services. In 2013<sup>11</sup>, survey data shows nearly a third of people aged 5 or older (32%) avoided or delayed visiting a dentist due to cost. This ranged from almost 11% of children aged 5–14 to 45% for adults aged 25–44. The current situation where 58.2 per cent of costs for dental health care are paid for by individuals as an out-of-pocket cost is clearly unsatisfactory and discriminates against those without the means to pay for treatment. The AIHW reports that almost one-fifth of insured adults (19%) who were required to cover their own dental expenses said it caused a large financial burden.

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

## Engaging consumers in resource allocation decisions and future sustainability

Continuing rapid advances in expensive health technologies combined with the ageing of the population means that difficult decisions about health resource allocation will become ever more necessary.

At the same time as technology continues to expand the scope of what is medically possible, and consumer expectations of the treatment possibilities that they and their loved ones will be able to receive similarly increases, the proportion of the working age population will be reducing. By 2050, there will be seven people aged 85 and over for every 100 working age people, compared to just three now<sup>12</sup>.

We will increasingly need to ask hard questions about our willingness and ability to pay for more expensive treatments. In particular, we need to be aware of the opportunity cost in other areas of social policy, such as the forgone opportunity to increase the quality of housing for Indigenous and disadvantaged people by choosing to otherwise invest in an expensive piece of health technology that may benefit only a few people.

While these decisions are often made by politicians and bureaucrats with little public scrutiny or involvement, CHA considers that the value judgements inherent in making these decisions require a more open and transparent process.

Both as a society and on an individual basis, we need to take responsibility for making judgements about where expenditure can be incurred – and, just as importantly, what we will not be able to fund. CHA recognises that some of these decisions may be difficult for governments, churches and individuals alike however that does not mean they should not be made.

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<sup>11</sup> <http://www.aihw.gov.au/dental/cost/>

<sup>12</sup> Institute the Actuaries. Green Paper. 2014

## How can we “Future proof” our health system?

This is important because our population, our climate and our health care needs are shifting. Health policy needs to plan for and move with these changes.

Our population demographic will undergo a rapid change in the coming years and by 2050, and it is estimated that there will be seven people aged 85 and over for every 100 working age people, compared to just three now<sup>13</sup>. Health care expenditure is higher at older ages, and the number of people, particularly the elderly, experiencing multiple chronic diseases, such as cardiovascular diseases, cancers, chronic obstructive pulmonary disease (COPD) and diabetes is increasing. Currently, chronic disease accounts for 85% of the total burden of disease in Australia<sup>14</sup>.

Without policy change, working age people will be required to support the rising health care costs of a growing and more expensive population. Health and residential aged care expenditure is estimated to increase from 9.67% of GDP in 2011-12 to 12.4% of GDP in 2032-33<sup>15</sup>. It is predicted that the working population will need to pay 1.6-1.9 times their own health expenditure over the coming years in order to fund the health care costs of Australia’s ageing population.

Improving technology, resources, and health outcomes means that healthcare is becoming more expensive, and our expectations of access to, and of what healthcare can deliver, are rising. Personal income also drives consumption of health care and as per capita income and the capacity to pay more for health care rises, so does demand, resulting in increased utilisation of health care.

The wellbeing of the Australian population faces other potential challenges in the future. Health is profoundly linked to climate via its influence on a large number of variables. The World Health Organisation estimates that climate change will result in approximately 250 000 additional deaths per year between 2030 and 2050; 38 000 due to heat exposure in elderly people, 48 000 due to diarrhoea, 60 000 due to malaria, and 95 000 due to childhood undernutrition<sup>16</sup>. An example of health impacts from high air temperatures, which exacerbate cardiovascular and respiratory disease, occurred in the heat wave in Europe, 2003, which caused more than 70 000 deaths<sup>17</sup>. Increasing frequency of extreme weather events are also likely to impact on infrastructure, including housing, medical facilities and other essential services.

## Financing a changing demographic and disease burden

The changing demographic and predicted increases in chronic disease pose a significant funding challenge. Systemic change is needed in order to finance the health care needs of this changing demographic.

Four main areas of focus for future-proofing our health system include; prevention of chronic disease, promoting healthy aging, increased health sector productivity, and funding reform. Efficient effective integrated systems are needed to reduce the impact of increasing chronic disease and an aging population and these concepts can be applied for long-term models. Investment now in research in the field of biomedical and biotechnology can greatly enhance the

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<sup>13</sup> Institute the Actuaries. Green Paper. 2014

<sup>14</sup> Evaluation The Institute for Health Metrics and Global Burden of Disease study. 2013.

<sup>15</sup> AIHW. Projection of Australian health care expenditure by disease, 2003 to 2033. 2008.

<sup>16</sup> WHO. Quantitative risk assessment of the effects of climate change on selected causes of death, 2030s and 2050s. (2014)

<sup>17</sup> Robine J. M., Cheung S. L., Le Roy S., Van Oyen H., Griffiths C., Michel J. P., Herrmann F. R. Death toll exceeded 70,000 in Europe during the summer of 2003. C R Biol. 2008; 331:171-8.

effectiveness of treatments and promote non-hospital based care. However, the question remains as to who will, and how to, fund the healthcare of an increasingly expensive population.

A number of funding model changes have been proposed and further discussions are needed to assess their validity. One proposed model of pre-funding healthcare, currently employed in a number of countries including Canada, requires the currently economically active working-age population to prepay costs. These funds are used to finance future public programs equitably across the population. Another pre-funding model, mandatory long-term care insurance, was implemented in Japan in 2000. In this model, funds are comprised of co-payments (10%) and insurance premiums and local taxes (90%) and are used to finance long-term care for those aged over 65. Other pre-funding options include promoting personal savings through tax incentives. The concern with pre-funding health care costs is additional financial burden on those who are already financially disadvantaged. Alternatives such as gradual retirement or flexibility of retirement age, allow more contributions and delayed payouts, have also been proposed although remain controversial.

### Acknowledge and invest in future health by addressing climate change

CHA believes that addressing the source of climate change is essential, with all aspects of government, industry and community tackling emission targets to promote sustainable living.

Interdisciplinary research is a powerful mechanism of change and can dramatically influence outcomes in this area. Further research into health risks and outcomes associated with climate change, but also research into renewable energy sources, agricultural research, disease prevention, poverty, migration, security, water conservation and water treatment are much needed. Dissemination of data and knowledge through education is essential to transform behaviours.

### Establish an independent authority that can evaluate potential medical and clinical interventions

In other countries, such as the National Institute for Clinical Excellence<sup>18</sup> in the UK, an independent authority that can provide evidence based guidance and advice for health, public health and social care practitioners has proved valuable. Such an authority could also be responsible for developing quality standards and performance metrics for those providing and commissioning health, public health and social care services including the PHNs.

### Address the financial impact of obesity

The prevalence of obesity is rising dramatically and with it are significant economic and social costs to all Australians. In 2008, there were 25% of people aged 18 years and over who were obese, which had increased by 8.4% over the previous four-year period<sup>19</sup>.

The impact of obesity in economic terms has profound consequences on many stakeholders. Employers and governments are obliged to finance the high cost medical treatments of these chronic health conditions and also compensate for the possibility of higher absences from work due to ill health and higher absenteeism.

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<sup>18</sup> <https://www.nice.org.uk/>

<sup>19</sup> Medibank - Obesity in Australia: financial impacts and cost benefits of intervention March 2010

In terms of direct costs, it has been estimated that obesity increase per capita inpatient expenditures by 45.5%, and outpatient expenditures by 26.9%. The increase in prescription drug expenditures was even higher at 80.4%. These estimates were then combined with obesity prevalence rates to calculate the impact on total annual medical expenditure and found that obesity increases medical expenditure by 9.1% (in the U.S, 2009 data) per annum or \$147 billion (US Dollars)<sup>20</sup>.

In summary, although the evidence is mounting that obesity is just as dangerous as public health threats of the past, a global or Australian focused strategy of prevention is far from being established as the problem is complex and it is unclear whether the lead role in strategies to address obesity should be taken by food companies, government or the individual. CHA advocates a joint approach by all stakeholders to enable the individual to make informed lifestyle choices about the dangers of obesity and associated health risks.

### Building a sustainable aged care service sector<sup>21</sup>

A major focus of aged care reforms to date has been increasing the opportunity for older people to choose to receive care in their own homes with the assistance of aged care packages.

However, the opportunity to receive care in the home is compromised currently because the number of packages is controlled at each of four funding levels and the number of places at each funding level does not align with the spread of consumer assessed needs. Hence many consumers prioritised by MyAgedCare are not able to access the funding level that matches their care needs.

CHA urges the Government to announce in the 2017-18 Budget its intention to no longer control the number of packages by funding level, but instead assign packages to individuals as prioritised by MyAgedCare. The budget control would instead be an annual cap on funding equivalent to that which would otherwise have resulted under the government commitment to increase the ratio for home care packages to 45 operational places per 1,000 people aged 70 and over by 2021-22.

A related issue that should be taken up in the 2017-18 Budget is to step up the release of home care packages, consistent with policy announced in the 2012-13 Budget to increase the overall target provision ratio to 125 operational aged care places per 1,000 people aged 70 and over by 2021-22, including, as noted above, a significant rebalancing to home care by increasing the target ratio for home care packages to 45.

It is disappointing that since 30 June 2011, the operational provision ratio for home care packages has increased by only 4.9 to 31.9, well below the target ratio of 45, and the overall operational provision ratio has increased by only 0.4 (from 112.8 at 30 June 2011 to 113.2 at 30 June 2016). CHA would like to see the Government to ramp-up the release of home care packages consistent with existing policy, and to increase consumer access to aged care packages that suit their assessed needs by removing the control of package numbers at each of the four funding levels.

In due course, the objective should be to introduce a system comparable to residential care where financial assistance for individuals depends on their assessed needs, and access is not controlled at each funding level.

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<sup>20</sup> The costs of obesity in the workplace. Finkelstein , DiBonaventura , Burgess , Hale .2010

<sup>21</sup> [http://www.cha.org.au/images/CHA\\_-\\_Pre-Budget\\_Submission\\_2017-18.pdf](http://www.cha.org.au/images/CHA_-_Pre-Budget_Submission_2017-18.pdf)