Public Health Association of Australia
submission on the Inquiry into the future sustainability of health funding in the ACT

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Introduction

The Public Health Association of Australia

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

Vision for a healthy population

The PHAA has a vision for a healthy region, a healthy nation, and healthy people, living in an equitable society underpinned by a well-functioning ecosystem and healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Background and discussion

The PHAA welcomes the opportunity to provide input to the Legislative Assembly’s Inquiry into the future sustainability of health funding in the ACT.

The reduction of social and health inequities should be an over-arching goal of national policy and that of the Australian Capital Territory and be recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on reducing health inequities. The ACT could play a leadership role in this respect. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

The PHAA consistently calls for preventive health policy frameworks which would – in addition to other inherent public goods – assist governments to frame financially sustainable approaches to the funding of health systems. In 2014 we provided a Submission to the Senate Select Committee on Health inquiry into and report on health policy, administration and expenditure.1
In 2015 the PHAA provided a Submission to the Commonwealth Parliament’s inquiry into best practice in chronic disease prevention and management in primary healthcare, which argued for an increase in government funding for comprehensive primary health care and health prevention initiatives that would improve the health and wellbeing for the community and create long term savings for the health budget. The issues addressed in those national inquiries, and in the current inquiry by the ACT Legislative Assembly, differ only in scale, and the recommendations to government made in those submissions apply equally to the policy frameworks to which the ACT Government should direct its efforts.

The notion of fiscal ‘sustainability’ of health systems

There is ongoing public debate about the notion of the ‘sustainability’ of health system expenditure, and whether or not various health systems are fiscally ‘sustainable’ at the present. The crudest implication of the term sustainability is that if a system is deemed to be fiscally unsustainable, the immediate government response should be to reduce expenditure. This reasoning is simplistic and potentially has serious implications for public policy-making.

Firstly, taken in fiscal terms alone, all public health systems – which are composed of a collection of state agencies and service provider corporations – are in reality nothing other than delegated subdivisions of their governments. It is these governments which decide both how much funding health systems are allocated, and how much they expend. Governments therefore make subjective decisions about the extent to which the accounts of their public health system entities are in expenditure-to-revenue balance at any point in time. (It is true that planned expenditure may be exceeded at margins in any given time period due to inability to constrain spending to budget, but that is a separate management question).

Furthermore, the extent to which any financial gap between the funds allocated to a health system and the funds expended by them is tolerable to a community or government is also a subjective political choice. Within the wider context of a government’s fiscal position, the fact that the health divisions of the government are operating at a nominal deficit may simply be absorbable into the government’s total financial position.

This would obviously be true if the other subdivisions of government activity are collectively achieving a positive outcome, but it may even be that a government is able to operate at an overall negative position for reasons of high fiscal or economic strategy. Governments have the capability of dealing with fiscal positions over medium and long-term time periods (decades or more), and are not in practice forced to react to results over short cycles (such as 1- or 4-year public reporting periods).

In short, the notion that a fiscal gap in a government health system is ‘unsustainable’ is an artificial construct. Any fiscal gap is itself a product of government choices, and the capability to tolerate a fiscal gap of any given size is also a subjective political choice.

All this would be true even of a single-level government. Of course, the federal nature of Australia means that the ‘sustainability’ of state and territory financial systems is an even more abstract idea. The scale of the Commonwealth-revenue-sourced contributions to the state/territory health service provision systems are in fact so great that significant alterations to their quantum alone can determine whether the latter are in fiscal balance.

For these reasons the use of the term ‘sustainability’ is misleading in regard to health system funding settings by governments. (Thomson et al 2009)

Alternative descriptions of the situation, such as health systems being “affordable”, or funding levels being “adequate” overlook the politically subjective nature of the fiscal position of health systems.
The social determinants of health

Population health outcomes are fundamentally the result of underlying structural factors, such as social determinants, institutional racism, the quality of housing, and access to appropriate primary health care. The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.

If governments want to improve and sustain the health of a population over time, these elements must be addressed. This means that sustainable improvements to the health of a population will ultimately depend on the quantum, quality, coherence and coordination of the health system and other government inputs in these areas.

The social determinants of health are responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. This is particularly pertinent when considering issues such as overall government health funding.

Health investment contrasted with illness expenditure

To engage with the ‘sustainability’ issue at a meaningful level it is vital to distinguish between two classes of financial outflow, which unfortunately are all too often merged together as one financial statistic.

The PHAA argues that financial outflows on preventive health care, or the maintenance of wellness, have the character of investments, whereas outflows on the redress of illness has the character of expenses. It is a mistake to group the two classes of outflows together collectively as costs.

Successful health investments make possible future health gains, or limit future health costs. By contrast, expenses made on illnesses or injuries are simply resources disposed of, which do not always generate future gains (other than in the sense of preventing an even worse – and thus more costly still – illness condition).

The cause-and-effect interactions of the costs (and benefits) of wellness and illness are dynamic, and their effect can be compounding. A community which allows itself, or sectors of itself, to worsen in various measures of health will over time inevitably experience more illness and injury, leading to increased economic and financial costs. Depending on political choices, such a condition will simply compound upon itself, worsening the economic vitality of the community and thus its ability to generate resources (including public revenues). Among other negative consequences such economic constriction would reduce the future resources available to maintain community health, perpetuating a vicious cycle.

By contrast, a community that is increasingly healthy will generate more resources (including – depending on political choices – disposable public revenue), some of which can be deployed on investments in better health and wellbeing particularly with a focus on those most in need, thus positively compounding the trends in the health of the community.

These dynamic relationships warn policy-makers against the obvious error of constraining health investment in the short term, where that would only induce in the longer-term higher demand for illness-addressing expenditure.

The key insight is that investments in health need to be differentiated from spending on illness and injury. Current government health system fiscal reporting does not do this in any transparent or useable manner. It is almost certain that in most national health system models, health investment on preventable care and wellbeing is too low, resulting in illness and injury expenditure being unnecessarily high. Governmental financial management and reporting systems do not currently use clear metrics for use in public policy discourse to expose these underlying fiscal dynamics.
The importance of setting the key decisions about health goals and targets

In dealing with the ‘how much to spend on health’ policy question, governments and the community first need to adopt some vision about what range of health and wellbeing conditions they aim to achieve. Unless decision making is guided by metrics, targets and data on the current position regarding health outcomes, judgements cannot be made about whether investments are adequate or not.

The design of a health system should involve setting a long-term strategy for investment in good health, resulting in a tolerably affordable burden of illness expenses.

If one specific goal of the health system is that the sum of the financial cost of the ‘wellbeing investments’ and the ‘illness expenses’ is the lowest possible figure over the longer term, then two policy results are inevitable. First, the plan to address this goal must be quite long-term in its framing, because the gains from improved population health can often take many years to fully manifest. Second, the level of wellbeing investment spending must be large enough to contribute to the desired minimization of the final cost.

It is also important to remember that even the crude metric of having the lowest possible spending total is itself a political choice.

Strategically minded governments should find themselves looking for an efficient mix of the two forms of resourcing. The challenge is how to identify an efficient overall model of health investments and illness expenses that is durable over the long term. In particular it may well be that models with total costs that are not the lowest of all possible models might well be the most attractive overall when all their benefits have been taken into account.

Tools to measure the long-term interaction of health system investments and expenses are currently lacking, and need to be found.

The economic and financial logic of preventive health – the negative cycle

The health status of the community is fundamentally linked to economic performance. In particular, there is a clear link between health status and productivity. Where health among the workforce – including employees as well as those who would launch and maintain businesses – is poor, productivity is constrained. Where health declines, productivity declines. These economic results are of key importance to economic modelling and economic management.

In addition, poor or declining health at the workforce population level will have a general tendency to cause greater rates of workplace health and safety impacts, as the workforce is more vulnerable to illnesses that arise in the course of work. Increased rates of workplace health and safety incidents in turn further reduce productivity.

In addition, productivity metrics can in turn be used to model impacts on government revenues through those forms of taxation which are based on employment and business vitality. Lower productivity means lower revenue.

The effect of such productivity impacts is measurable. Treasuries and other economic modellers have become adept at estimating the economic impact of various levels of productivity and productivity change. Moreover, poor or declining rates of population health directly drive cost pressures on the health system, in the form of demand for treatments of high or increasing rates of illness. This is the cost pressure which is perhaps most visible to all Australian governments, in the form of demand-driven health sector expenditure growth currently running at around 7%.

The above trends constitute not merely negative cause/effect associations, but a negative cycle. Poor or worsening health can become a compounding problem, since worsening economic vitality and government revenue would mean that the economic and financial resources that might otherwise have been available
to individuals to maintain good health, and to governments to provide health care, would be constrained and/or decline. This is the very scenario apparently facing Australia’s population and its governments.

**The economic and financial logic of preventive health – the positive cycle**

The tendencies just mentioned also have a positive cycle, corresponding to the negative one. Where population health is strong, or better still improving, then productivity both in the workforce and in business will also tend to improve. The economic strategy of Australia’s governments are premised on achieving continuous improvement in rates of productivity. Governments should recognise that improving population health is itself a form of economic stimulus.

Population health-driven increases in productivity – and with it decreased occurrence of workplace health and safety incidents and illnesses – also feed directly into increased government revenues.

Better rates of health also helps constrain at least some of the pressure of demand for health system services that address illness and injury.

**Avoiding fiscal leakage**

In striving for a model of fiscally affordable health care, whatever model is sought, every opportunity to avoid needless expenses – forms of ‘leakage’ from the systems available resources – should be seized.

There are several well-known inefficient outflows in every health system including over-servicing (the provision of costly illness care where it is not needed), adverse incidents (health treatments which are defective in any sense, worsening an illness) and extractive practices (rent-seeking and profit-taking by goods and service providers to a degree beyond what is reasonable to reward them for their inputs).

Governments administering health systems should address all these forms of ‘leakage’ with appropriate policy regimes and operational measures.

**The ability of state/territory jurisdictions to make public policy**

It should be acknowledged that the reasoning outlined here applies most strongly when a jurisdiction has a high level of control over its health system and the forces impacting on it.

The Australia national health network is a complex system shared by the national and state governments in its design, and also shared with the private sector in its service delivery.

The state-level governments, despite nominally being the primary purchaser and provided of health services, cannot alone make major policy decisions.

This applies with extra force to the ACT, which operates with large degrees of cross-border movement of people seeking health care, and where the provision of preventive health care investments may not feasibly be limitable to ACT residents. Treating the problem of health system management as limited by jurisdictional boundaries serves little public purpose; holistic national policy approaches are far more appropriate.

**Problems of perverse political pressures in current conditions**

It is worth noting that the current political climate, focused as it is on the simplistic ‘cost-constraining’ approach to health system funding, places perverse incentives on political decision-makers. These include the following:

- By constantly promoting the theme that expenditure totals must be constrained, the current dialogue crowds out sensible discussion of what may be the best overall model of investment and spending in the health of the community.
• By failing to distinguish between preventive health and wellbeing investments and illness spending, current reporting of financial flows, and debate about such flows, are distorted.
• By pressuring state ministers and financial controllers to simply reduce ‘costs’ in crude terms of financial outflows, and framing this political objective in a short-term timeframe, decisions are directed towards selecting outflows that can be cut to the greatest quantity, as fast as possible, with the least apparent political adverse reaction. In such conditions decision-making is distorted, perhaps seriously.
• By inhibiting decisions to invest significantly in greater preventive health and wellbeing programs because ‘new’ spending seems to breach current political imperatives, the current climate works adversely to what may be the best long-term funding decisions for health systems.

Targets and reporting
To ensure greater success in preventing chronic diseases, it is essential that the nine targets identified by WHO are appropriately reflected in Australian preventive efforts. A commitment from all the national, state and territory governments to achieve the targets set by the WHO is needed to ensure that the burden of illness and injury are constrained. This commitment should include detailed plans and strategies for key risk factors and provide for governments to publically report against the progress in reaching these targets.

Public reporting is also important in order to increase accountability for preventive actions. The treatment sectors enjoy considerable recognition in relation to the public reporting of health targets (such as emergency department waiting times). In contrast, the public reporting of preventive health progress is limited, meaning that there is less accountability for these targets.

The abolition earlier this decade of two important reporting mechanisms, the National Partnership Agreement on Preventive Health (NPAPH) and the Council of Australian Governments (COAG) Reform Council, means that there is no longer an ongoing commitment tied to tracking the progress of chronic disease prevention. The NPAPH required governments to report progress against targets, but there was no imperative to make these reports public. Similarly, the COAG Reform Council, who was responsible for overseeing the progress of a number of national agreements and national partnership agreements, did not publish any reports measuring the progress of strategies under the NPAPH.

Other task forces have emerged to take the place of the NPAPH and COAG Reform Council. We would urge the ACT Legislative Assembly and the ACT Government to support the Australian Prevention Partnership Centre, which was established in 2014 to establish a new way of addressing the gap between evidence, government policies and health system practices.
Response to the Inquiry Terms of Reference

PHAA offers specific comments on terms of reference (a), (b), (c) and (e) as follows.

ToR (a): The efficiency of current health financing

This TOR calls for particular attention to “the alignment of funding with the purpose of the ACT’s health services, including the provision of quality and accessible health care to patients when they need it”.

Clearly, the Territory should ensure that its program of expenditure is aligned with its stated strategic goals, such as the service provision cited. The problem here is that the broad purpose cited in this ToR does not distinguish between spending on illness services and investments in preventive healthcare.

ToR (b): The nature of health funding and how it improves patient outcomes including innovative or alternative programs such as hospital in the home and walk in centres

The great majority of health funding can be said to improve health outcomes in the sense of addressing an illness or injury. Innovation in all health programs is to be welcomed. The overall approach should be that all service providers should regularly review their methodologies and technologies for providing health care services, and should use evidence about outcomes to guide service reform.

With this in mind, governments should avoid using data about funding and spending rates on particular health services as itself a metric of success. The true metrics of success is are those which measure health outcomes.

ToR (c): The sources and interaction of health financing in the ACT

Funding for health expenditure in the ACT comes from a mix of private expenditure (including private spending that is mediated through health insurance), Commonwealth Government expenditure and ACT Government expenditure. Given the integrated nature of the national health system, only the last of these three is directly controllable by the ACT Government.

ToR (e): The relationship between hospital financing and primary, secondary and community care, including the interface with the National Disability Insurance Scheme and residential aged care

As argued earlier, the level of hospital funding is a matter of subjective government choice. A better measure of success is the rate at which the population has genuine need of hospital services. This can be brought down by appropriate investment in primary and preventive health services, and indeed also by appropriate secondary health services. The higher up the service ‘pyramid’ spending takes place, the less cost-efficient it is in the task of maintaining good health.

Hospital spending is appropriate and necessary for any illnesses and injuries. But the fewer such illnesses and injuries actually exist, the better the health system is performing.

The National Disability Insurance Scheme involves elements of both services to address injuries and illnesses, and also preventive health measures. As with any other aspect of health system policy, the maximum possible emphasis should be placed on preventive health investments in people with disabilities.
Conclusion

These are the key points in this issue:

- The simplistic understanding that ‘sustainability’ of public health systems – which implies that their cost base must be reduced without regard to more nuanced impacts – should be rejected.
- Better population health investment leads governments to a stronger financial position, both through increased revenues and constrained costs.
- Prevention is the most important and most cost-effective means to strengthen population health.

The ACT Legislative Assembly and Government should:

- Develop a distinction in its statements of strategic goals and service delivery targets for the health system, and in its reporting of financial expenditure, between ‘preventive health investments’ and ‘spending to redress illness’.
- Increase ACT Government expenditure on preventive health investments. This will bring substantial benefits in terms of both health and costs in years ahead.
- Maintain ACT Government expenditure on all other health care services which are cost-effective (ie: increased preventive health funding should not be at the expense of other important health services).
- Argue through COAG and other mechanisms for increased Commonwealth expenditure on preventive health investments and support the adoption of preventive health policies nationwide.
- Argue through COAG and other mechanisms for current Commonwealth expenditure on private health insurance subsidisation to be transferred directly to strategic public health system expenditure on preventive health.
- Support the work of the Australian Preventive Partnership Centre.

The PHAA appreciates the opportunity to make this submission.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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References

4. Average annual rate of growth in total health expenditure for Australia from 2004-05 to 2014-15 was 6.99% - AIHW health expenditure report 2015-16, Table 2.1.