35 Woolrych Crescent,
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Dear Commissioners,

My interest in this inquiry is multifaceted. Firstly, as someone with a physical disability I have probably had more contact with health services, at a younger age, than most people. As such, the public policy debates surrounding the health system (whether this is in reference to the public or private sector) is of great interest to me.

In conducting its inquiry, I believe the Commission is faced with three main problems. The first is public perception of "what a health service is" and who is principally responsible for delivering it; the second problem is the political response, at both State and Federal level, to the first problem. Meanwhile, the third problem relates to the regulation of various health care workers.

I learned about public perception of the health system, as a member of the Northern Beaches Community Consultative Health Planning Group (NBCCHPG). This was a consultative group established by the Area Health Service and the three local Councils on Sydney's Northern Beaches, ostensibly to facilitate community input on the question of the future development/configuration of public health services in this region. In practice, this dissolved into one question: "What will be the medium to long-term fate of the two public hospitals located at opposing geographic (and, in many ways, political) ends of the northern beaches?"

There are two important assumptions here. The first is that the provision of health services, even in a middle-to-high income area, will have a significant public component. The second, as I indicated in my submission[1] to the NSW Legislative Council inquiry into the *Operation of Mona Vale Hospital*[2] public debate equates health with hospitals. Certainly, this was the local experience, as well-organised lobby groups combined with various councillors to create near panic in the community about the future of health services.[3]

A further problem is an aversion, at least in some quarters, to private provision of what some perceive not only as public goods, but as goods *which can only be provided by the public purse.* As such, when I presented a proposal to the NBCCHPG suggesting the location of publicly funded emergency medical facilities with private

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[1] *See* Appendix 4

[2] *See generally* http://www.parliament.nsw.gov.au/cgi-bin/isys/isyswebext.exe?op=get&uri=/prod/parlment/committee.nsf/0/746f8b13bea5882fca25700c007f4990/$FILE/Final%20Committee%20Report%2026%20May%202005%20-%20Inquiry%20into%20Mona%20Vale%20Hospital.pdf

[3] *See* Appendix 3. While this document is addressed to the NSW Local Government Department's inquiry which led to the dismissal of Warringah Shire Council (the Daly Commission), I wrote my submission from my perspective as a then former member of the (disbanded) NBCCHPG. The destabilising influence of local politicians was a central plank in my argument for the council's dismissal. For further information on the Daly Commission see http://www.dlg.nsw.gov.au/warringah/

hospitals, this received a less than warm welcome.[4] While responding with a document which elaborated on the proposal,[5] the experience taught me how some groups with a hardened view and specific agenda will readily appropriate for themselves the title "community representatives" disparaging any dissenting views as either "not from the community" or opposed to "the community position". Of course, assessing what a "community" position constitutes is much like reading opinion pools; the results depend on who you ask, when you ask them, how you ask them and what you ask them, as well as a multitude of other possible factors.

Regardless of the above, I would still offer my NBCCHPG proposal as something which has wider application. As the population of Australia ages and the number of working-age, income-earning taxpayers declines, we will have to look at other modes of service delivery. This does not mean that I am opposed to public delivery or public oversight. As Appendix 2[6] shows, a robust legislative and regulatory framework is still needed to ensure transparency and accountability in the provision of a public good paid for by the taxpayer. It was an unfortunate surprise for me to find that the Continence Aids Assistance Scheme contract was not awarded with reference to any legislative or regulatory instrument and, as a result, I could not pursue inquiries via the *Administrative Decisions (Judicial Review) Act 1977* or the *Financial Management and Accountability Act*. As long as all government contracts with private entities could be scrutinised publicly, by virtues of these enactments or the like, I would be fairly confident about significant private provision of public health services.

However, a further caveat would be that for the purpose of fully investigating a consumer's complaint about a health service provider, 'commercial-in-confidence' considerations could not be used as an argument by either the State or the service provider in denying an investigator access to information, unless the complaint was a corporate entity.

And while we are looking at private means of delivery, we also need to consider the public labyrinth of administration and mismatched resource allocation that is Medicare. In saying this, I acknowledge that my circumstances are fortunate enough to be able to maintain private health cover. Equally, I have also been in (and am currently attempting to re-enter) the paid workforce. When employed, one could not help but be appalled that I spent a good proportion of each fortnight "working for Canberra" (paying tax). While the Government does provide me with a 30% rebate on private health insurance, it has failed to hand back the Medicare Levy. Why should those, like me, who wish to keep our private insurance, prop up the insurer of last resort with a special levy? General taxation or what from the Government's view is 'consolidated revenue' should take care of this matter.

Some authors argue that private health rebates are inherently inefficient and amounts to an industry subsidy. For example, Livingstone and Ford have written that:

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[4] See Appendix 1, pp. 17-20 This document is also available at http://www.nsh.nsw.gov.au/majplanning/NthBeach/Reports/value/003671354.pdf

[5] *See* ibid., pp. 21-22

[6] This document was my submission to your Report No. 15: Cost Recovery by Government Agencies, available at http://www.pc.gov.au/

"…What other Australian industry has its prices supported by a direct 30% subsidy from government? Duckett and Jackson have highlighted the cost to the government of the 30% Rebate is larger than the combined budgetary assistance to mining, manufacturing and agricultural production industries…"[7]

However, does it follow that there is the complete absence of a case for private health insurance and (at least in the short to medium term) an equal absence of an argument to continue to support the private system? Livingstone and Ford would say so, pointing out that:

"…Of the contributions made by various funding sources to Australia's health care expenditure, governments contribute the lion's share, nearly 70% of the total, with individuals contributing the second greatest proportion at around 18%. (Private health insurance), in contrast, contributed a total of a comparatively modest $4 billion, or less than 9% of total recurrent expenditure. And it is important to note that PHI contributed nothing to research…"[8]

I look at such figures and ask: is the state contribution sustainable? I think not, though acknowledge that Livingstone and Ford think differently, seeing the private funds as being "vastly less efficient than Medicare".[9] To an extent, the difference in view comes from a sense of ownership and priority. I want to own my own health, consult my own doctor and, where necessary be admitted to my preferred hospital and be treated by my preferred surgeon. I do not want to go on a public waiting list, to be admitted into a facility, to have a procedure cancelled and, if it is not cancelled, to have it conducted by some junior doctor I have never met.

Yet, Livingstone and Ford argue that "Medicare is a cornerstone of what remains of our fabled Australian virtues of a fair go and social justice".[10] Really? How is it just to spend years on a waiting list for surgery? Furthermore, don't Australia's farmers hold an equally fabled and virtuous position in the Australian psyche, if in a different context? However, Livingstone and Ford note withdraw of subsidies to them without the same objection.

The health care debate will not be advanced by resorting to rhetoric. Neither the public nor the private sector health care systems work very well. Additionally, Australians need to have it suggested to them that it is important for each individual to have dominion over their health, rather than assuming that the State will be there to provide care all the time. After all, whose health is it?

Livingstone and Ford are justified in some of their criticisms of private health insurers. For example, they state:

"…(The) success of the Howard government's attempts to prop up (Private Health Insurance) PHI can perhaps be gauged not just by the increase in PHI coverage that

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[7] Livingstone, Charles and Greg Ford, *Paying for our health*, Dissent, Autumn/Winter 2003, p.56 (Article cited in Dr. James Gillepsie, *The Politics of Health (Pol 341) Readings*, Department of Politics and International Relations, Macquarie University, 2003)
[8] Ibid, p.57
[9] Ibid, p.59
[10] Ibid

resulted…but also the continuing controversy over PHI premium increases, and most recently by the news that Medibank Private, the Commonwealth owned PHI fund, has recorded a loss of $170 million and will consequently axe a premium discount program, presenting consumers with a second premium increase within five months…"[11]

At present, customers purchase private insurance from a company, which presents them with a health insurance package. Would it not give consumers more power if they (or brokers they hired) mixed and matched packages and premiums according to an individual client's needs. Therefore, I could purchase optical cover from one company, dental from a second and surgical from a third, in much the same way as many Australians keep a portfolio of investments; some of their wealth will be in share, with perhaps another portion in property.

Competing on individual services could act to drive down price. Meanwhile, the government could weight its rebate. This would mean that the lower your income, the greater the rebate for maintaining private health coverage. Indeed, a parallel might be drawn with the superannuation co-contribution scheme for low income earners. Furthermore, the proposal could be expanded to a part public/part private coverage mix. Where an individual was prepared to purchase some health services privately, but could not afford a complete package, they could still attract rebates and, where possible, referral by the public system to private service providers for the health needs they could not cover themselves. This sets up a definite reward system for those prepared to take control of their health.

Meanwhile, the public provision of health in Australia has generated numerous anomalies. The first is the artificial restriction on medical graduates, by means no seen in any other tertiary education discipline and, for reasons of public finance, rather than for a lack of willing applicants or community need. John Patterson and Peter Phelan explain that Medicare provides payments to registered GPs and specialists for a set range of services. Therefore, to try and limit growth in the costs of Medicare, the Commonwealth:

"…(controls) the number of Australian residents entering medical schools. Every university faculty *other than* Medicine is free to take in Australian applicants as full-fee paying students if they fail to qualify for HECS-funded places. Australia's publicly funded universities are *forbidden* to take full-fee paying medical students…"[12]

This brings us back to State-funding and State-control. In using the word "State" I am referring to either the Commonwealth or State governments. For as long as the public is content to let the bureaucracy tell us how, when and sometimes *if* we get treated, we will be stuck with the kind of mismatches your Issues Paper identifies. In the comments above and in the attached documents, I have tried to outline alternatives I see to the current arrangements. These involve individual consumers and the private

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[11] Ibid., p.57

[12] .Paterson, John and Peter Phelan, *A Severe Case of Elephantiasis: The Need to Reform The Health System*, Quadrant: January-February 2003, p.53 (Article cited in Dr. James Gillepsie, *The Politics of Health (Pol 341) Readings*, Department of Politics and International Relations, Macquarie University, 2003)

sector taking more active roles, while the Government takes more of a pure policy and oversight role.

Yours sincerely,

Adam Johnston