

# Funding a viable and effective health sector in Australia

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**WISeR**  
Informing Decisions







***Funding a viable  
and effective health  
sector in Australia***

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## EXECUTIVE SUMMARY

Funding of the Australian health sector into the future is to say the least a vexing issue. Currently health services spending is approximately 9% of Australian GDP – which is around the average for developed nations. But in Australia and globally, the demand for health services is expected to continue to increase – driven by ageing of population and community choice. There are also questions about type and effectiveness – the desired balance between institutional care, informal care and preventative health. Projected demand, based on increasing ‘lifestyle’ health problems (e.g. Type 2 diabetes, obesity) and an ageing population (e.g. dementia and chronic conditions), will see the health sector responding to a changed mix of disease burden. Health spending will also evolve as technological change affects health care treatment and costs, and as the population’s expectations for timely and quality health care increases with rising incomes.

The funding and regulation of the health sector in Australia reflects the complexity of the sector itself, with State and Territory governments primarily responsible for the management and delivery of hospitals and other major parts of the health system (including public health), but with much of the funding originating in general taxation revenues from the Commonwealth. The funding relationship between Commonwealth and State with respect to hospitals was set out in the National Health Reform Agreement of August 2011, but the 2014 budget has effectively terminated that agreement.

The Medicare Levy itself raises about \$14 billion per year relative to public sector spend of some \$100 billion. There is a total spend (Commonwealth and State Governments, and private expenditure) to the order of \$150 billion.

The funding of health care in Australia involves a complex interrelationship between the public and private sectors, and although consistent with the push since the 1990’s towards competitive practice there has been more private sector involvement (e.g. through publicly funded and contracted delivery of services by the private sector), the public sector still has the main share of funding responsibility. Despite the high proportion of public funding and provision compared with many other industries, the private proportion of total health care expenditure is higher than in many other OECD countries and the public-private balance varies significantly from one sector of the health industry to another.

In addition to specific health care funding issues, in recent times there has been an overarching macroeconomic focus on sustainable public sector budgets. In response to the global financial crisis (GFC), sovereign governments at risk of default and with concerns about the current level of debt have mooted significant changes in funding in health (and other sectors). This has intensified in recent months with the expanding public sector deficit linked to a slowing of revenue growth as commodity prices fall.

In this context, there has been an increased focus on recognising private benefit and ensuring funding mechanisms limit the incentive for overuse. Tax mechanisms to increase funds for health care are limited as Australia is in the medium taxing band of developed countries (as assessed by tax relative to GDP), while the balance of how taxes are raised is potentially distortionary (with a greater reliance on income taxes – and specifically company income tax). Despite increases in public sector deficits and increased debt, the net public sector debt levels in Australia remain quite low relative to other developed countries.

It is also noted that State government (and local) funding mechanisms have diminished over time,



particularly after the introduction of the GST. As a consequence State budgets are under significant stress.

Given the complexities involved it is important to avoid reviewing options in a simplistic way. The inter-relationships and consequences of alternative options need to be fully understood so that the best choices can be made. Options need to be understood in the context of health outcomes, as well as outcomes for the economy as a whole.

An integrated and holistic approach to health care funding needs to be adopted to ensure that equity and efficiency objectives are realised and unintended consequences avoided. Major considerations exist in four domains as follows.

### **Domain 1 – Improved efficiency in service delivery**

While most expect that demands on the health sector will increase, opinions differ about how these demands might be met. Increased funding is of course one option, as is funding to improve the effectiveness of the system. The latter includes changing consumer practice (health risk prevention), directing demand to more cost effective (but appropriate) levels of service, introducing cost saving technologies and so on. Improving effectiveness requires enhanced information and management systems in existing entities and appropriate de- or re-regulation of the sector to enable the implementation of practices that produce better outcomes from the equivalent use of resources.

However it should be understood that:

- Productivity enhancing reforms need funding and finance.
- There is a link to the incentives created from Domains 2 to 4. Funding structures need to provide a foundation for innovation and to improve effectiveness rather than embed current practice.

### **Domain 2 – The mix between public and private funding**

The public good/merit good arguments of health service provision are undeniable. The provision of universally accessible and high quality health services necessarily requires significant public funding. Competition for public funding has, however, intensified at the same time as the demand for health services is growing. There are calls on government revenues for education, for infrastructure, for welfare support and safety nets. As a consequence health agencies are under greater pressure to contain costs. Meanwhile policy makers have sought to move more people from reliance on the public health system to the heavily subsidised private system.

Over-reliance on private funding creates structural market failure issues. It also has significant implications for access and equity, exposing low income households to an increasingly residualised public system and a prohibitively expensive private system. It is clear that current safety net responses (particularly in terms of the reliance on Private Health Insurance) do not adequately address this. In short, Australia already is at the higher end of private funding of health care, and the evidence suggests that substantially shifting the burden away from public funding would be expected, on the evidence, to introduce more problems than it would solve.

Moreover, greater use of private funding means that there will be some price and income based rationing of access – which will create a relative disadvantage for the socially disadvantaged, and require the development of effective safety nets.

### **Domain 3 – Increasing the use of tax revenue**

Taxation revenue available to fund health services can be increased by one of two means:

- Redirecting from other public expenditure items; and/or
- Increased taxation revenue opportunities.



Australia is a middle level taxing nation less reliant on broad based consumption tax and more reliant on income tax (particularly company tax). A conclusion that might be reached is that there should be an increase in the GST (both by broadening the base and increasing the rate). A 1% increase in the rate of GST would raise over \$4 billion of new revenue based on current consumption levels. Whilst some may consider this will have advantages with respect to economic and administrative efficiency, the regressive nature of the GST is problematic. Low income earners pay a greater proportion of their income in GST than higher income earners. As such, increasing the rate of the GST would need recognition within the social safety net, which would offset the administrative efficiency argument.

Additional options include:

- Increasing the income tax rate;
- Increasing the Medicare levy AND targeting the revenue towards health;
- Removing or reducing income tax deductions or rebates;
- Increasing taxes on a range of goods and products (e.g. petroleum levies, resource rent taxes); and
- Increasing taxes on products that have a specific linkage with health outcomes (i.e. target public 'bads', such as alcohol and tobacco, fast food) and allocate the extra revenue to the major impacted sector - the health system.

Under this domain, possible alternative public revenue options for consideration include:

*Bequest (on estate) tax:*

Bequest taxes are taxes on inheritances, or on transfer of assets. There is currently no such direct tax in Australia, whereas most other countries have some form of a bequest tax (generally at low rates). A bequest tax rate of 1% would raise an estimated \$250 million in 2015, rising to \$400 million by 2020 and \$800 million by 2030. This form of tax was generally supported as being efficient in the Henry Review. In general terms it is also favourable in terms of equity implications. The biggest issues are avoidance behaviours that might be induced, administration costs and potential issues in valuation and liquidity of certain types of assets.

*Removal of Private Health Insurance subsidies:*

Abolishing subsidies for private health insurance would increase taxation revenues by approximately \$6 billion per annum, and abolishing the rebate for higher income earners would save further amounts. This is consistent with recommendations of the Henry Review.

*Medicare levy:*

The Medicare Levy currently raises \$14 billion after the recent increase in rate to 2% to fund the National Disability Insurance Scheme. An increase by a further 0.5% raises an additional \$3 billion per annum. Doing so would ignore the recommendations of the Henry Review that this scheme should be morphed into general income taxation. Further, more radical reform of specifically funding public health care costs through a significantly increased Medicare levy are also possible, to increase it (with 'almost offsetting' reduction in income taxes) and tie it to the level of health expenditure.

*Mineral Resource Rent Tax:*

Implementation of the original Henry Review recommendations relating to the taxation of resources and land were estimated to lead to a gain to revenue of around \$7 billion in 2010–11 values when fully mature, representing an effective opportunity to revisit this with appropriate consultation.

#### *A 'Robin Hood' tax:*

The concept of a tax on financial transactions has been mooted as a possible option for addressing the needs for additional tax revenue – and has been called a 'Tobin' tax or a 'Robin Hood' tax. There are strong efficiency arguments mooted with respect to such a tax limiting speculative transactions. However, one of the attractions is that it would raise a large amount of money for a small imposed rate, and secondly that it can be considered a progressive tax in that people with greater wealth will undertake larger and more frequent transactions. Such a tax would raise up to \$16 billion annually, at a 0.05% rate of tax. The Henry Review did not pursue this tax strongly based on concerns that it would have unexpected and negative outcomes.

#### *State Health levy:*

States could increase their direct funding of health services through the application of a health levy on households (as an additional levy on top of the emergency services levy). A levy on households in SA (approximately 650,000 households) of \$100 per household would raise \$65 million a year. This would need to be introduced with safety net considerations. Further there are equity issues, particularly in the context of the aged population where older people can be asset rich (through the family home – on which the levy is based) but income poor.

#### **Domain 4 – Effective user pays**

Where increased user pays is implemented it needs to be designed in such a way as to be effective, and to not just been seen as extracting more money, but also to be effective in driving sensible behaviours (i.e. creating the right incentives). The complications associated with this include:

- The level of funding needs to recognise the extent of private benefit involved. An over-reliance on private funding means that public or social benefits will not be recognised in resource allocation
- Consumers will have to make choices about what they purchase from a limited budget. This will create equity issues and households and individuals from lower income and wealth groups will have more limited access. Given the cost increases being faced in housing and housing services (i.e. electricity, water) which are bringing low income households under pressure, the potentially inequitable implications would need special consideration.
- If the argument about user pays is about improving demand management this will only be effective if there are minimal market failures on the supply side, or if the regulatory framework is itself effective.

To ensure a user pays approach is successful in achieving the desired outcomes, significant structural change is necessary. Otherwise this approach may simply increase the overall cost of health care, or transfer the burden. It is necessary to:

- Ensure changes to the Private Health Insurance market act as an effective safety net, but also reduce what is known in economics as 'moral hazard' (taking risks as one is protected against the consequences of one's actions) and other market failure outcomes.
- Increase competition in markets – including:
  - Use of professionals in roles they currently are precluded from (e.g. nurses or chemists being able to perform roles in the system currently limited to doctors)
  - Increasing access more generally.

## Summary of options

In summary the following revenue options might be considered:

1. Increase the rate of the GST to 11%, and broaden its base – without any offset in income tax rates – and transparently direct the funding to health services.
2. Introduce a Federal bequest tax of 0.5%, again with the funding raised transparently and directed to the provision of health services.
3. Introduce a Financial Transactions Tax at 0.05%, with the funding raised transparently directed to the provision of health services
4. The Commonwealth revisit aspects of the Henry Review, and specifically:
  - a. Remove rebates and subsidies in the public health system, and
  - b. Design and implement an effective and workable resources tax
5. Increase the Medicare Levy, matching and tying it to the expenditure needs of the health sector (after agreed reforms).
6. Undertake a comprehensive review of the way that Health Services are managed and delivered to maximise efficiency and effectiveness while maintaining universal standards of health care service delivery.



# 1 HEALTH DEMAND INTO THE FUTURE

In 2012-13, Australia spent in the order of almost \$150 billion on health services. Approximately 70% of our community’s spend on health was funded from the public purse and the balance from private sources<sup>1</sup>. This expenditure is in excess of 9% of GDP – or Australia spends almost 1 in 10 dollars it earns on health care and services.

As illustrated in Figure 1, the proportional spend of national income that has occurred on health has steadily increased over the last decade from below 8% of GDP in 1999-2000, to over 9% of GDP. This growth has been both in government or public spend (increasing at 7.6% per annum relative to GDP, increasing at 6.6% in nominal terms) and in private expenditure (7.5% per annum). In general the expectation is that demand for health services will continue to increase, even though it has somewhat plateaued (as a proportion of GDP) over the last few years.

**FIGURE 1: SPEND ON HEALTH (PROPORTION OF THE GDP), AUSTRALIA, 1999 TO 2013**

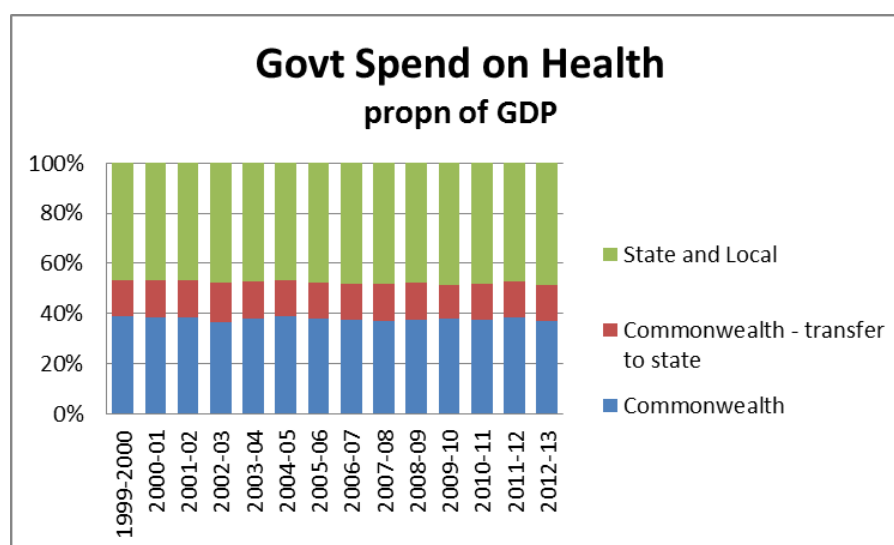


Source: ABS National Accounts

Figure 2 indicates that the increase has been focussed in State government provided services – which have increased at 8.3% per annum while funding transferred from the Commonwealth to the State had increased at the lower rate of 7.8% per annum.

<sup>1</sup> Note that both the aggregate spend and the amounts in each area are undoubtedly an under-estimate of the spend on health if we take a broader view of health and include ‘alternative’ and preventative health spend, such as expenditure on exercise and food that have health outcome motivations.

FIGURE 2: GOVERNMENT SPEND ON HEALTH (PROPORTION OF THE GDP), AUSTRALIA, 1999 TO 2013



Source: ABS National Accounts

Table 1 provides an alternative perspective of the balance of funding that is involved (note that the last category is effectively worker's compensation insurers).

TABLE 1: TOTAL HEALTH EXPENDITURE, BY SOURCE OF FUNDS AS A PROPORTION OF TOTAL HEALTH EXPENDITURE

	Australian Government (%)	State/territory & local (%)	Individuals (%)	Health insurance funds (%)	Other non-government (%)
2001-02	44.0	23.2	17.5	8.0	7.2
2002-03	43.6	24.4	16.7	8.0	7.3
2003-04	43.6	23.6	17.5	8.1	7.3
2004-05	43.8	24.0	17.4	7.7	7.1
2005-06	42.8	25.3	17.4	7.6	6.9
2006-07	42.0	25.8	17.4	7.6	7.2
2007-08	43.2	25.5	16.8	7.6	6.9
2008-09	44.1	25.1	17.1	7.8	6.0
2009-10	43.7	26.3	17.5	7.5	5.0
2010-11	42.7	26.5	18.3	7.6	5.0
2011-12	42.4	27.3	17.3	8.0	5.0

Source: AIHW (Australian Institute of Health and Welfare, 2013)

Concerns about rising expenditure are in part fuelled by the ageing of the population. However the literature suggests that rising national health expenditure is likely to be driven by a combination of factors including:

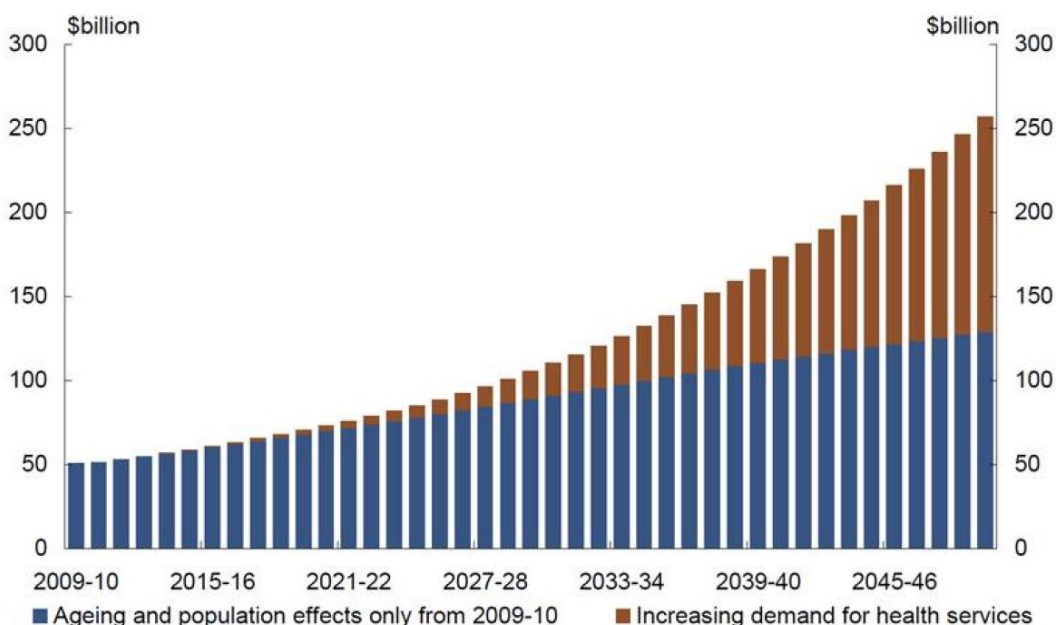
- Population growth;
- Economic growth resulting in higher real per capita incomes, with health care being seen as a 'superior good' in economic terms and consumption increasing as a share of the consumption bundle for average incomes;
- Relative price changes – with the AIHW indicating that over the last decade health inflation has exceeded general inflation in terms of gross national income by 0.24% per year (Australian Institute of Health and Welfare, 2013) and increases in the cost of pharmaceuticals and technology; and

- Improvement in socio-economic status, through education and access to health information.

A paper by the representative advisory committees on health (2005, p. 1) indicated a decade ago that this increased spending trend was occurring, and that it was not all a consequence of ageing, concluding that the “literature surveyed suggests that real non-demographic growth in health care demand is likely to be in the order of 0.3% to 0.9% above per capita GDP growth, with the total growth in real health care expenditure projected to rise by between 4 and 4.5% per annum over the next ten years to 2014-15” – a prediction that, even with the unexpected advent of the GFC, has been realised.

The balance between demographic factors (ageing) and other factors in terms of impact on health demand into the future is illustrated in Figure 3 as modelled or forecast by the Australian Treasury.

**FIGURE 3: TOTAL AUSTRALIAN GOVERNMENT HEALTH EXPENDITURE WITH AND WITHOUT NON-DEMOGRAPHIC GROWTH (IN 2009-10 DOLLARS)**



Source: Astolfi et al (2012) – derived from Australian Treasury forecasts

This has been supported in a range of other studies including:

- The Productivity Commission (2005) concluded that “Macroeconometric studies find that ageing has not been the most significant factor influencing past growth in health expenditure. This is unsurprising because the degree of ageing to date has been modest compared with what is projected to occur over the next 40 years.” However, the Productivity Commission did acknowledge that ageing had been part of the growth in demand stating that “...the Commission estimates that ageing has added about 0.5 percentage points a year to the per capita growth rate of health expenditure.”
- A study by Lowthiam et al. (2011) confirms there has been a dramatic rise in emergency transportations over the period 1995 to 2007-08 which was beyond that expected from demographic changes and that the rates of consumption increased across all age groups. But the study also noted that the rate increases were greater in older age groups, suggesting the issues may well be inter-related.

The concern about the burgeoning demand growth has translated to the call from many quarters about need for reform to avert an impending 'budget crisis', despite merit good<sup>2</sup> positioning of health services. However, there are alternative views that this is not necessarily a foregone conclusion:

- Tordrup (Tordrup, Angelis, & Kanavos, 2013) undertook a survey of health care stakeholders in the 28 EU member states and other countries<sup>3</sup> collecting preferences on a variety of revenue-generating mechanisms and cost/demand reducing policies to manage the health care system moving forward. Across all groups, their survey indicated that the highest preference was for policies to modify lifestyle and implement more extensive screening within risk groups for high burden illnesses as the most effective way to manage the expected burgeoning demand. Importantly there was a broad consensus amongst respondents not to reallocate resources towards health from social security/education. As expected, industry respondents were generally more in favour of market-based interventions and an increased role for the private sector in health care financing/delivery while stakeholders from academia, government, national health services and insurance viewed more restrictive purchasing of new and expensive technologies, and (to varying extent) of higher income/corporate taxes more favourably.
- Roberts et al. (2012) reviewed the targets of the National Health Service (NHS) in England. The forecast was for around 8% growth in underlying demand for health services. This report suggested that about half (4%) of this was likely to be delivered by general productivity increases. So while productivity improvements can and will moderate the expenditure push, the report also raised concerns that in the current budgetary environment in the UK, the other half of the demand increase will not be available from the public purse. Therefore it will remain unmet unless there is an even more extensive focus on improved practices, such as better case management of chronic disease patients.
- A Committee for Economic Development of Australia (CEDA) sponsored research paper which focussed on the issue of "spiralling health costs" and the implications for the economy provided quite specific recommendations as follows:

*To introduce dynamic efficiency into the healthcare sector and to reduce the level of intergenerational equity transfer, major reforms are needed to the way healthcare costs are funded and services delivered. Improvements to incentives could be achieved by:*

- *Aggregating all health funding at the level of the individual;*
- *Having financial risk reside with competing health funds through insurance arrangements, introducing managed competition, eliminating fragmented responsibility and cost shifting;*
- *Linking public healthcare budgets and community expectations of healthcare services to economic capacity to pay, via a fully hypothecated Medicare levy that funds healthcare expenditure; and*
- *Introducing pre-funding for healthcare costs by quarantining a portion of the Superannuation Guarantee rate, or increasing the Levy, so that approximately three per cent is set aside to cover healthcare costs. (Healthcare: Reform or ration, 2013) (CEDA, 2013, p. 7)*

There are also other factors to consider:

- Cyclic and short term drivers. An OECD study (van Gool & Pearson, 2014) points out that there is an extensive theoretical literature on why economic crises might produce poor health outcomes, but note that the analysis is mixed – overall economic downturns are affected by adverse outcomes for some, but not all indicators. Increasing unemployment rates are highly linked to lower health care use. Importantly though, they found that the GFC has put pressure on public sector budgets through

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<sup>2</sup> An economics term referring to a commodity or service that is generally regarded by society or government as deserving public finance – a basic individual right.

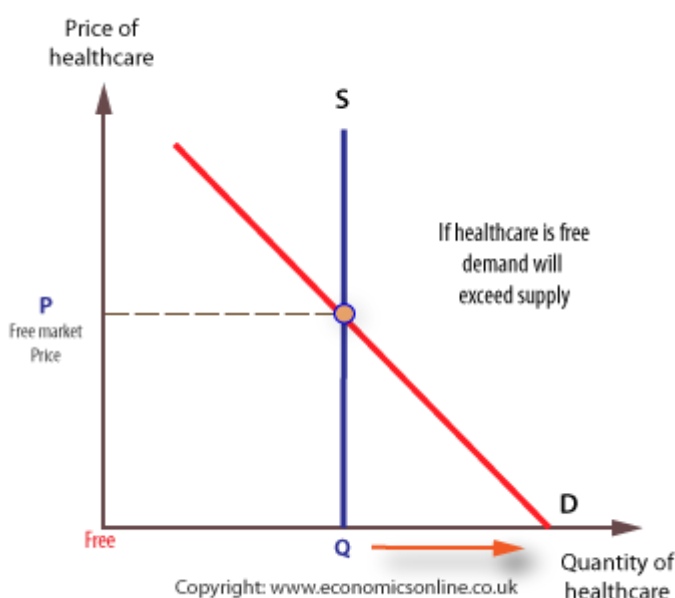
<sup>3</sup> Including Norway, Iceland, Switzerland, Australia, Russian Federation, Canada and New Zealand.



reduced taxation revenues and therefore forced structural reforms to try to improve health care systems management and gain efficiencies in this context – attempting to address demands effectively with lower expenditures.

- The discussion above is based on aggregate outcomes – while the literature identifies an extensive variation in predicted demand across services. Again some of this will be age based (increased demand based on the needs of a higher proportion of people in older groups) but some again will be lifestyle and influenced by choice.
- It needs to be acknowledged that the method of funding used will actually impact on demand level – in aggregate and by service. Health economists generally review demand patterns with the following observations:
  - Where people pay less than the value of service there will be excess demand. The standard economic diagram is presented in Figure 4. What should be noted is that where price is not used to ration, then alternatives such as waiting lists or waiting times become important – and people with lower value of time will be less disadvantaged in this regard (while they would generally be more disadvantaged where price is the rationing device). Obviously the degree of excess demand is dependent on the price elasticity involved – the less price elastic (i.e. the more vertical the demand curve) the less the excess demand.

FIGURE 4: HEALTHCARE AS A FUNCTION OF PRICE AND QUANTITY



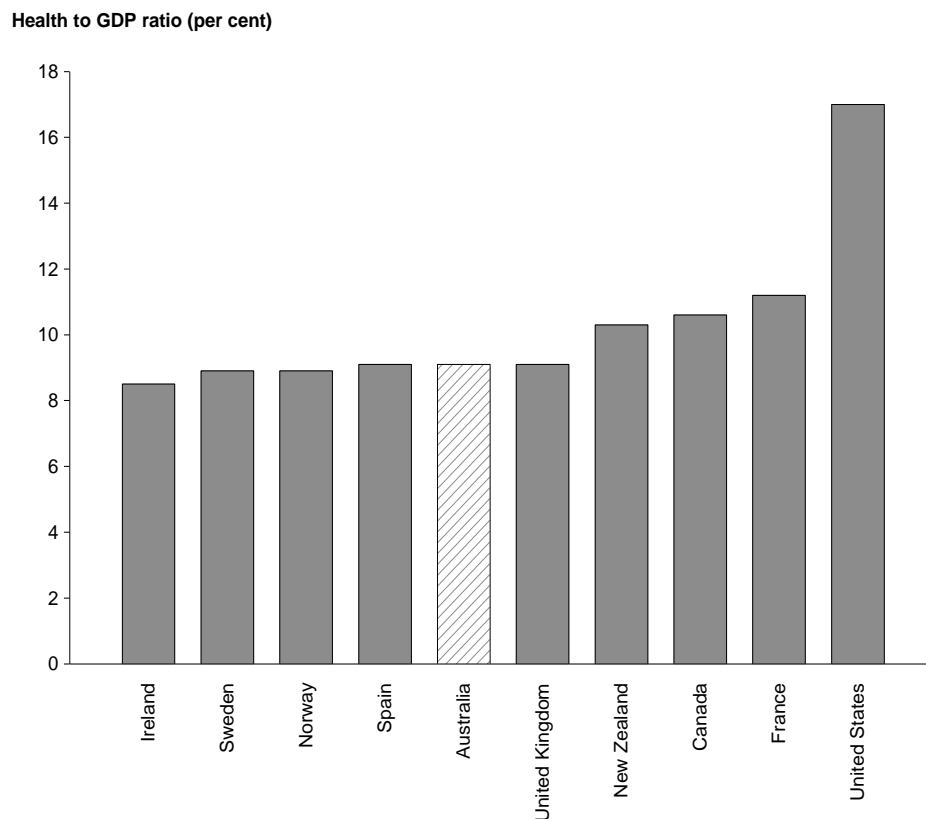
Source: [http://www.economicsonline.co.uk/Market\\_failures/Healthcare.html](http://www.economicsonline.co.uk/Market_failures/Healthcare.html)

- They consider the structure of the health sector and the market behaviour therein as ‘idiosyncratic’ (Richardson, 2001) – with the main relationship which creates this characteristic being the influence of doctors over patients or, the theory of ‘Supplier Induced Demand’ (SID). Simply put, this is the implication that the doctor is at the centre of all health sector relationships. Richardson notes that while this theory is well founded, it is not decisive in permitting reform to improve outcomes.

## 2 GLOBAL PRACTICE WITH RESPECT TO HEALTH FUNDING MODELS

The proportional spend of national income on health in developed countries (OECD) generally ranges between 7% and 11%, with Australia slightly below the average of 10% but ahead of the median of 9.0%. The outlier influencing this average is the USA.

**FIGURE 5: HEALTH EXPENDITURE AS A PROPORTION OF GDP, SELECTED OECD COUNTRIES, 2011**



Source: AIHW (2013)

Over the last couple of years there has been a significant 'halt' in health spending growth across the OECD – from an average real growth of over 4% in 2007/08 and 2008/09<sup>4</sup> – to 0% growth in 2009/10 (which was expected to be repeated in 2010/11) – but there was significant variation across countries (Morgan & Astolfi, 2013). Morgan and Astolfi also indicate that the lapse in spending has been strongest in government spending, but also present in private (insurance and personal). It is expected that this halt will be short lived. As budgets are (slowly) brought back into order and consumer confidence restored, the level of expenditure growth is likely to resume. The slowdown in growth has been most marked in the nations hit by severe economic difficulty (e.g. Ireland, Greece, the United Kingdom etc) and less in countries like Germany, Canada, New Zealand and the United States.

AIHW data (Table 2.1 – AIHW database) indicates that the real growth in Australia was 4.8% for the period 2001 to 2006-07, but was maintained, and even increased in the last half, and was still running at 6% in 2010-11 and 2011-12. Figure 1 (see page 1) presents the ratio of spend to GDP – noting that Australia has not experienced the same drop in

<sup>4</sup> The average growth rate in health expenditure in the early part of that decade (2001-2004) was 5.5%-6.0%, and this declined to 4% for the last part of the decade (2005 – 2009).

economic activity as some other countries over that period - though current conditions are cause for some concern.

Around the world there are generally three broad level options used for financing national health systems and most systems have some mix of these mechanisms:

1. **Tax Funding** - where healthcare is funded by the taxpayer out of general government funds, using tax revenues from all sources. Healthcare is then provided free to patients, with resource allocation being driven by need, rather than income and the operation of the price mechanism (note that the Medicare levy is a slight variation on this, with the levy being a 'targeted' taxation amount);
2. **User Charges** - where patients pay doctors or hospitals directly for their treatment, such as paying a fee for each visit to the doctor, for each treatment or medicine prescribed, and;
3. **Insurance** - which can be divided into two options:
  - a. **Social health insurance** (which is counted as public funding in OECD data), where employees and employers make compulsory contributions towards healthcare and where provision is also free at the point of need. This is often called the European model of healthcare funding, and
  - b. **Private health insurance** (PHI) where individuals pay premiums (insurance fees) to private companies, and then 'claim' when receiving treatment<sup>5</sup>. 'Top-up' private insurance means taking out insurance cover in addition to taxpayer funded or social insurance.

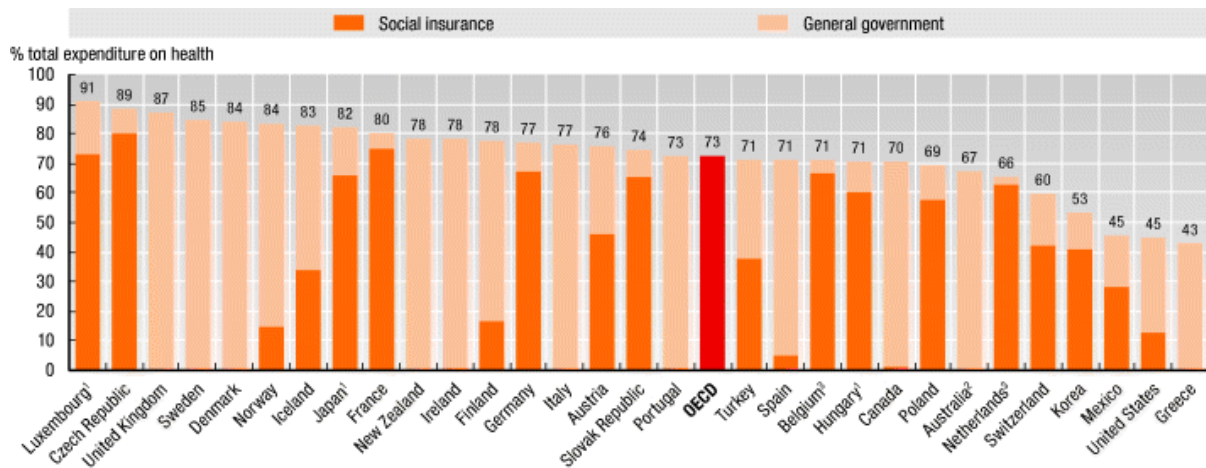
Looking at the 'private' sector components in a slightly different way – the private contribution can have several very different forms (Scherer & Devaux, 2010):

- Co-payments or co-insurance with public expenditure;
- Supplementary expenditures which substitute for public expenditure (which are very important in Australia); and/or
- Private provision of services not publicly funded at all.

These systems can and usually do overlap – with individual access to the system coming from a combination of these services. Figure 6 illustrates the private and public spend mix in various countries (including Australia) for 2005.

<sup>5</sup> Even within this context there are complexities and issues, with for example the PHI sector in Australia moving from a predominantly not-for-profit structure to, now, a predominantly for-profit structure. In 2006, 85% of Private Health Insurers were not-for-profit, while by 2012 it was more like 30% (Deloitte, 2012)

FIGURE 6: HEALTH EXPENDITURE AS A PROPORTION OF GDP, SELECTED COUNTRIES – PRIVATE AND PUBLIC MIX, 2005



Source: (Foley, 2008)

The broad level conclusion that can be derived from Figure 6 is that the practices can be generally divided into three groups:

- Countries where health care is primarily (>80%) funded by public funding (i.e. out of taxation revenue), such as UK and Nordic countries,
- The other extreme, where private funding delivers the majority of services - with this dominated by the USA. The PHI approach dominates healthcare funding in the USA, although it is subject to the *Obamacare* debate given the large numbers of American citizens who have no private insurance, or who are significantly under-insured, and
- The group in the middle, at around the OECD average of 73% public funding. Australia is at the lower end of this. Though the chart does not show it, public funding includes Medicare (i.e. a tax levy specifically focussed on health care).

However, as discussed further below, all countries are grappling with the issue of how to fund the expected increases in demand, and whatever their current base, they are reviewing effectiveness.

### 3 FUNDING AND FINANCING OF HEALTH CARE IN AUSTRALIA

Discussion around resourcing of public services generally makes two distinctions – though in much of the literature they are confused concepts:

- **‘Funding’** refers to the raising of revenue for operations, and to cover the cost of capital relating to an investment (e.g. through general revenues in the taxation base, user charges, or the receipt of grants, subsidies and contributions).
- **‘Financing’** describes how payment for an investment outlay is accommodated. This could be, for example, through an entity (e.g. a hospital) accessing its own funds (e.g. cash held in a bank account) or by borrowing.

Infrastructure Australia summarises this distinction:

*It is important to differentiate between financing and funding. The term funding, as used in this report, refers to how infrastructure is paid for. Ultimately, there are only two sources of funding for infrastructure, government investment or direct user charges. This is opposed to financing which refers to the way in which debt and/or equity is raised for the delivery and operation of an infrastructure project.*

In the end the two are related, as the funding must be available through ongoing sources to cover the ongoing financing costs (debt coverage, opportunity cost and depreciation).

These definitional differences are not adopted in much of the health literature – where the discussion is primarily about funding rather than financing (though the term financing is generally used) and often in the following discussion of the current funding mechanisms at use in Australia the term ‘financing’ is inaccurately applied in the source information.

Table 2 provides a summary of the major funding mechanisms for the various segments of the health care market. While dated 2005-06 – there has not been substantial change to the overarching structure of the health system; however, there have been internal changes within this structure

**TABLE 2: FUNDING ARRANGEMENTS FOR SELECTED HEALTH SERVICES, AUSTRALIA, 2005-06**

Public hospitals	Mainly tax financed	No user charges except for private patients
General practice	Mainly tax financed	No user charges for 77% bulk billed
Diagnostic services	Mainly tax financed	No user charges for 87% bulk billed (pathology) and 61% (diagnostic imaging)
Specialist medical services	Mainly tax financed	Lower bulk billing rate (26%) results in more user charges
Private hospitals	Tax financed for 23% of expenditure through PHI rebate	Mainly user charges; fully covered by PHI except for agreed deductibles
Dental services	Tax financed for 19% of expenditures for limited public dental services and through PHI rebate	Mainly user charges with some cover by PHI
Allied health	Tax financed through some limited MBS items and in public health	Mainly user charges with some cover by PHI
Prescription pharmaceuticals	Mainly tax financed	User charges subject to a safety net

Source: (Foley, 2008, p. 12)

The funding mechanisms used by the Australian Government to resource health services include:

- Medicare Benefits Schedule (MBS) component of Medicare, providing rebates to private patients for medical services provided by privately practising doctors, specialists and limited services from some allied health practitioners.
- Pharmaceutical Benefits Scheme (PBS) component of Medicare, providing rebates to private patients for a wide range of prescription pharmaceuticals.
- The National Health Reform Agreement (last negotiated in 2011), including the public hospital component of Medicare and provides grants to state and territory governments for the provision of free hospital treatment as a public patient. Noting that while the 2014-15 Commonwealth Budget withdrew significant financial support from this Agreement, the Federal Government haven't entered into subsequent negotiations with the co-signatory States and Territories about related changes to the content or reporting arrangements contained in the Agreement.
- National Partnership Agreements: grants to state/territory governments for a range of specific programs and for health infrastructure (note that many of these were terminated in the 2014 Commonwealth Budget proposals, and a significant number of other NPAs were not refunded after coming to the end of their funding period).
- Rebates for private health insurance premiums which subsidise the fees of ancillary health services and treatment as a private patient in hospital (public and private).
- Grants and payments to government and non-government health service providers for a range of health services (e.g. radiation oncology, pathology and primary care medical services) to improve service access and quality.
- Health services for war and defence service veterans.

While public funding covers 70% of the health sector spend, the private health sector (for-profit and not-for-profit providers) plays a significant role in delivering health services in Australia. Most medical, allied health practitioners and pharmaceutical prescribers are in private practice (self-employed, in small practices or increasingly in larger corporate practices) and charge a fee-for-service. Private hospitals provide a third of all hospital beds (in around 600 hospitals), and over half of all surgical episodes requiring the use of an operating room. Private providers also deliver most high-level residential aged-care beds

Public funding (and delivery) is supported by private health insurance (and injury compensation insurance) for hospital treatment as a private patient and for ancillary health services (such as physiotherapy and dental services) provided outside the hospital. As noted above private sources fund around a third of all health care in Australia. To encourage people to take out private insurance, there is the carrot of a tax rebate for people with health insurance who earn below certain levels (\$90,000 for singles, and \$180,000 for families, with reduced amounts for higher incomes) and the stick in that taxpayers who have a taxable income above a certain level AND without private health cover will pay a Medicare Surcharge Levy of 1%-1.5% (on top of the base Medicare Levy).

In 2014-15, taxation revenue from the Medicare Levy (including the Medicare Levy Surcharge) was budgeted to be \$14.2 billion (up from \$10.5 billion in 2013-14, due to the introduction of the surcharge). This compares with the budgeted health expenditure of \$66.9 billion, major items include MBS expenditure of \$20.3 billion, PBS expenditure of \$9.4 billion, the Private Health Insurance (PHI) rebate involved expenditure of \$6.3 billion and assistance to the states for public hospitals of \$15.1 billion

There are in the order of 40 registered health insurers. Private health insurance can cover part or all of hospital theatre and accommodation charges to private patients in either a public or private hospital, a portion of medical fees for services provided to private patients, allied health services, prevention and management programs for chronic disease, some dental services, optometry and spectacles, and ambulance transport.

The PHI system is regulated and insurance amounts are controlled by the Government. As at June 2014, 11.1 million Australians had private hospital insurance cover (47.2% of the population), and 13.0 million had ancillary or general treatment cover, including separate ambulance cover (55.2%)<sup>6</sup>.

In terms of out of pocket expenses in 2009-10,<sup>7</sup> Australian households spent an average of \$65 per week on medical care and health expenses, or 5.3% of their weekly expenditure on goods and services. The main items were:

- Accident and health insurance - \$26.50 per week or 40.5% of the total of \$65, with sickness and accident being 6.2% in this.
- Health practitioner's fees \$18.99 per week (28.9% of the total) – with the largest payments to dentists (\$7.23 per week), followed by specialists (\$6.23 per week).
- Medicines, pharmaceutical products and therapeutic appliances - \$17.88 per week (27.3%).

The proportion of spend was higher for lower income groups (6.9% for the lowest income quintile) and was extremely high (11% of income) for those on aged pensions, indicating that relying on health insurance is less of an option for those who are more disadvantaged.

The ABS National Health Survey – in 2011-12 provides the following statistics on health care characteristics for Australians:

- 91.1% of people have consulted at least one health professional in the last 12 months. However people living in areas of relatively high disadvantage were less likely to have seen a dentist in the last 12 months than people living in areas of low disadvantage (35.9% compared with 59.2% respectively), and similarly for a specialist (30.1% compared with 35.7% respectively) – which is of relevance in the context of acknowledging that dentist and specialist visits are not as broadly covered by Medicare, and require either personal payments or PHI.
- 1 in 4 (24.9%) Australians have attended at least one medical facility in the last 12 months (being admitted to hospital as an inpatient or visiting an outpatient clinic, emergency/casualty or day clinic). Those 75 years and over had the highest attendance at medical facilities, with a rate of 40.0% (with almost one-quarter being admitted to hospital in the last 12 months).
- 57.1% of all people aged 18 years and over had private health insurance, which was held by far fewer (47.2%) of the 18-24 year cohort. Noting that of those without PHI, 58% said they did not have cover because they could not afford it.

Private health insurance provides added benefits to insured individuals such as choice of doctor, choice of hospital and choice of timing of procedure. Private health insurance can also assist with meeting the costs of private services which are not covered by Medicare, such as dental, optical, physiotherapy and podiatry services.

The Commonwealth Government uses a number of measures to encourage participation in private health insurance as set out above. These measures include the 'carrots' of the Federal Government Rebate, Lifetime Health Cover and the 'stick' (for those above the targeted income levels) of the Medicare Levy Surcharge.

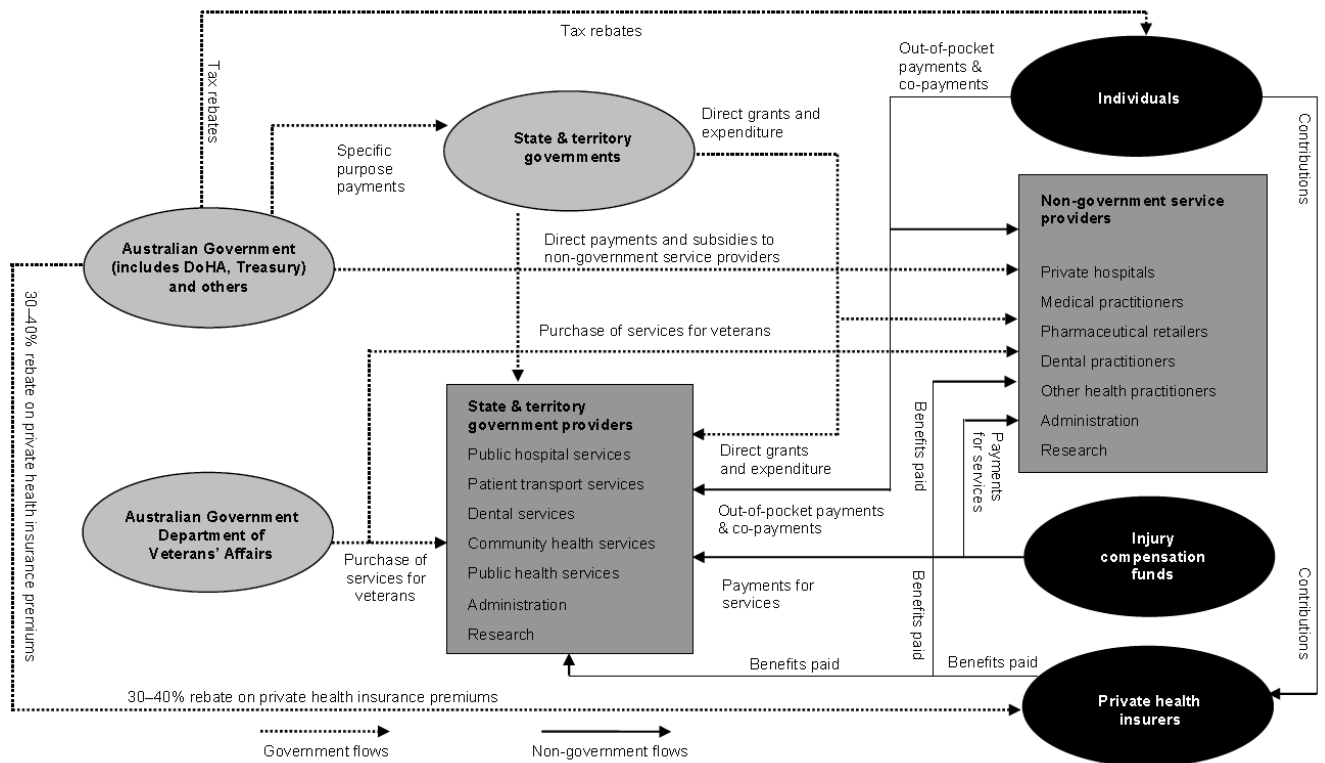
It should also be recognised that there are a range of other supports offered to the health sector, with the main benefits occurring where the provision is structured as a not-for-profit health. This includes salary sacrificing and fringe benefits tax (FBT) concessions. The Henry Review argued that these concessions should be removed, and replaced by grants but to this point this has not been implemented.

<sup>6</sup> Source: Private Health Insurance Administration Council - <http://phiac.gov.au/industry/industry-statistics/data-tables-membership-and-coverage/>

<sup>7</sup> Source: ABS Household Expenditure Survey, 2009-10, Catalogue 6540

Given the complexities of the system a visual schematic of the funding system for health care is a useful tool by which to consider the interrelationships that might exist between decisions. Figure 7 provides an illustration of the funding sources, the relationships and the type of products financed. What is difficult to illustrate are the implications of 'changing' specific types of funding, as many of these implications are behavioural. For example, increasing the rate of private health insurance and requiring individuals to cover a greater proportion of some costs would cause people to potentially opt out and rely even more on the publicly funded part of the sector (the National Health Survey indicates that lack of value for money is a major reason why some people do not carry PHI).

**FIGURE 7: THE STRUCTURE OF THE AUSTRALIAN HEALTH CARE SYSTEM AND ITS FLOW OF FUNDS**



Source: (Australian Institute of Health and Welfare, 2013, p. 3)

As noted, the relationships depicted in the above diagram are dependent on a complex system of regulations and relationships – particularly the Medical Benefits Scheme (MBS) on the one hand and the National Health Reform Agreement (NHRA) on the other. With respect to the latter, the 2011 NHRA was seen as a significant step to clarify roles, and to establish shared incentives for better use of resources. The Agreement included the introduction of activity based funding and a national efficient price concept to better align funding with activity, and to improve access to GP and primary health services. The 2014-15 Federal Budget proposed significant changes in this regard, and especially, as Price Waterhouse Coopers (2014) explains:

- Hospital funding - the previously agreed hospital funding arrangements will not be implemented, and from 2017-18 will be linked to CPI and population growth – with the important concept of activity based funding no longer 'in the mix'.
- Medicare Locals will be replaced by far fewer Primary Health Networks, which will include greater private sector involvement.
- The cessation of the National Partnership Agreements on preventive health and improving hospital services will take almost \$600 million out of the system.



The Federal Budget contained other changes around the Medicare payment scheme:

- The most publicised has been the \$7 co-payment for bulk-billed GP and pathology services. This was designed to cover the \$5 reduction applied to all patient visits for these services, along with a \$2 administration fee to cover costs associated with the collection of the \$5 from bulk bill patients. This measure was estimated to save \$3.5 billion over the forward estimates (with the states able to introduce patient contributions for GP equivalent visits to emergency departments). Whilst retaining the essence of the proposal, the Federal Government scrapped the bulk-bill elements of their proposal on 9 December 2014.
- The existing Pharmaceutical Benefits Scheme co-contribution scheme was increased for individuals to pay an additional \$5 towards each PBS prescription (with an increase of 80 cents for concession card holders), saving \$1.37 billion a year.
- Indexation of some Medicare Benefits Schedule fees and the Medicare Levy Surcharge and Private Health Insurance Rebate thresholds was paused (saving \$1.67bn).
- There would be an expenditure increase offset against the above revenue measures, with the establishment of a Medical Research Future Fund of \$20 billion (although it is likely there would be a corresponding reduction in other forms of medical research funding).

Other Federal Budget measures include:

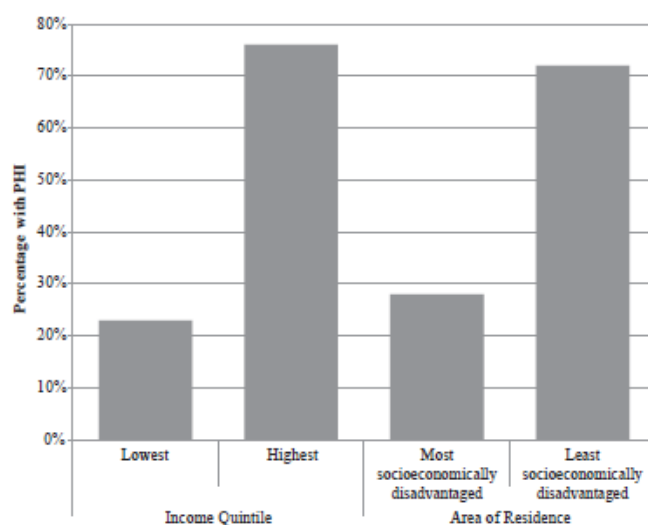
- Merging existing agencies, to establish a new Health Productivity and Performance Commission.
- An additional \$140m for eHealth and the Personally Controlled Electronic Health Record.
- Increased aged care funding achieved through replacement of the aged care workforce supplement with additional general aged care funding (\$1.5bn).
- Cutting an existing payroll tax supplement paid to aged care service providers (\$653m).
- Reducing the annual growth rate in the Commonwealth Home Support Programme from 2018-19 to 3.5 per cent above indexation (previously 6 per cent).

## 4 CRITICAL ISSUES

Australia sits in the middle of global practice in terms of the amount of health demand that is funded by public sources and the amount that is privately funded. In looking forward to possibilities for new revenues, the balance of public to private funding, and the relationship to public and private benefits must be kept in mind. From the literature, it is generally agreed that while private funding causes people to make conscious decisions about the need for a service - an overemphasis on private funding involves a number of market failure outcomes:

- **Under-supply** - the opposite problem to excess demand if the good is provided for free or below value. Pricing based on private assessment of value or benefit means there is a failure to recognise the public good component involved, in that an individual's health outcomes has implications for others, with the following implications:
  - An individual may develop a more serious health issue (chronic or infectious) from not dealing with symptoms early enough – increasing the damage of an episode and the costs of treatment. Information about illness and wellness is, like most items, becoming more pervasive and people might access 'google doctor' for information rather than pay money. This may lead to decisions that are only partially or ill-informed, with problematic results.
  - Contagious illnesses/diseases may be left untreated and will be liable to spreading more quickly.
  - Resources for other community members may be more limited (e.g. increased sick days taken by workers, is at a cost to employers).
- **Access and equity issues** – with 'rationing' of the service based on who can afford the service. As noted elsewhere, the rationing of access to health care services by the use of price mechanisms means that access is based on the individual's economic circumstance, countering the context of health services as a merit good. Figure 8 illustrates the point of access outcomes vividly in terms of the proportion of people who hold PHI insurance – with the rates of access much reduced for lower income groups, or those who live in socially disadvantaged areas. This is also the case in the context of direct out of pocket expenses – with many indicators suggesting that cost of living pressures for lower income groups have become an increasing issue in recent times.

FIGURE 8: COMPARATIVE % AGE OF AUSTRALIANS WITH PHI DEPENDING ON INCOME AND LOCATION



Source: (Law, 2011)

- **Mixed model** - An additional problem occurs where the delivery mechanisms are mixed (i.e. a combination of free or subsidised services and full fee services). Where this occurs there can be ineffective outcomes, “individuals naturally turn first to the services for which they do not pay anything, even though other interventions might be faster, better for them and less costly to society as a whole.” (CMAJ News, 2011). It is very hard to get the incentives right in such a complex system and where information deficiencies exist in the way they do.

Wanless (2004) undertook a major review of the British National Health System (NHS) which as mentioned earlier is primarily publicly funded. The review recommended in broad terms that the current system, based on funding through general taxation be retained as the basis for providing health services in the UK. This recommendation was based on the view that the system achieved the right balance between equity and efficiency. The report was:

- Critical of PHI, suggesting a system over-reliant on this method of funding:
  - **Was inequitable.** People were often without PHI because they could not afford it, or did not understand the risk. These disadvantaged people inevitably have less choice and slower access to care as they are reliant on the over-burdened public system.
  - **Had high administration costs.** The Australian industry in 2012-13 had premium revenue of \$18.0 billion, and investment and other revenue of a little over \$0.6 billion. They paid out benefits of \$15.4 billion and had management expenses of \$1.6 billion, or management expenses relative to revenue of 8.8% and an aggregate surplus of \$1.0 billion or 5.9% of revenue.
  - **Had no incentive for cost control.** The problem of third party payment arises where the insurance provider (the third party) bears the cost of any claim, and there is an incentive by providers to inflate claims and squander scarce resources, and little incentive from those receiving the services to monitor direct costs. It results in insurance suppliers simply passing on the cost to all policyholders.
- Against the use of out-of-pocket payments, because they lead to inequity and what Wanless called ‘regressiveness’. However, it accepted that the NHS should consider charging for non-medical services like bedside televisions and phones. Wanless also recommended that the government should attempt to provide greater choice for patients.

It should be noted that public funding also has some issues in an economic context. As discussed earlier the major issue is excess demand. But it may also have other unintended consequences such as, where government intervenes to increase the supply of healthcare on a subsidised basis, there is a potential government failure in what is known in economics as ‘moral hazard’ – where one person takes more risks because someone else has agreed to bear the burden of those risks. This means that individuals, knowing that they can get free and effective healthcare, might fail to take steps to avoid the risks that the healthcare insures against. Examples of possible behaviours might include:

- Poor diets and over-eating, because people know that there is free treatment for the problems linked to obesity, such as tablets for high blood pressure.
- Smoking, because of treatments available for medical consequences.
- Drug abuse, because emergency treatment is freely available.

A second possible issue is the lack of signals with respect to effective provision. In traditional markets, the better providers build customers, make better returns and reinvest in expanding their reach. Health economists often advocate that in health, with the need for public funding, better outcomes can be achieved by creating internal markets in order to reduce inefficiencies, also referred to as quasi markets. They have become increasingly seen as a means of allowing the price mechanism some role in healthcare resourcing. Patients can exercise their choices, electing to be treated in the

hospital of their choice so that resources are allocated more according to consumer preferences. Sub markets through contracting out for non-essential services, such as cleaning and security are also seen as adding possible efficiency. This even extends to the context of infrastructure delivery – with private provision of buildings (through public private partnerships).

This section briefly explains the complexity in the current system, and the inevitable debate whenever a change is mooted. It is evident that health delivery suffers from the potential of market failure (public goods, merit goods, externalities) and accordingly it cannot be left to private sector provision and will struggle if private sector provision provides the predominant funding. However, it can also suffer from potential government failure, which in turn requires either provision of contestability, and/or good regulatory and accountability.

## 5 STUDIES INTO TAXATION AND GOVERNMENT FUNDING SYSTEMS

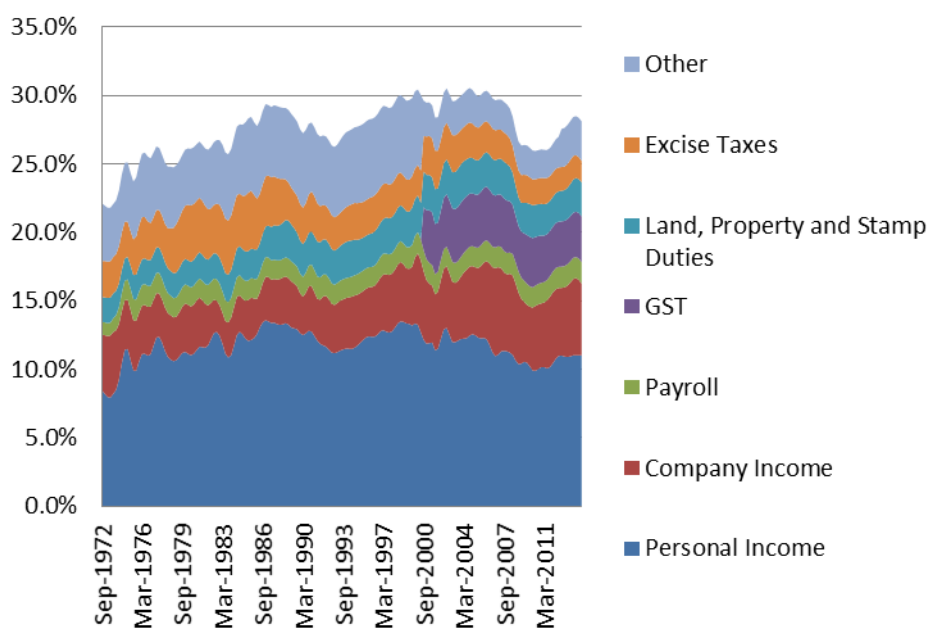
### 5.1 TAXATION AND GENERAL GOVERNMENT REVENUES

Taxation revenue is the largest source of funding for health services. The Medicare Levy amounts to \$10.5 billion with other general revenues amounting to \$56.4 million required to cover the rest of the health related Commonwealth budget.

Over the last 30 years, there has been a steady growth in taxation revenue as a proportion of GDP in Australia, from a little over 20% of GDP in the early 1970's to over 30% in the mid 2000's. In the first couple of decades of this period, the growth was across all taxation types, but since the late 1980's the growth came about from increases in corporate income tax and the introduction of the Goods and Services Tax (GST), with some offsetting declines in other areas).

However the Global Financial Crisis (GFC) has seen a significant dip in taxation revenue relative to GDP – and this has been across all taxation categories. It is now slowly recovering.

**FIGURE 9: TAX REVENUES BY TYPE (% OF GDP)**



Source: ABS Catalogues - this includes taxation revenue for the 3 tiers of government.

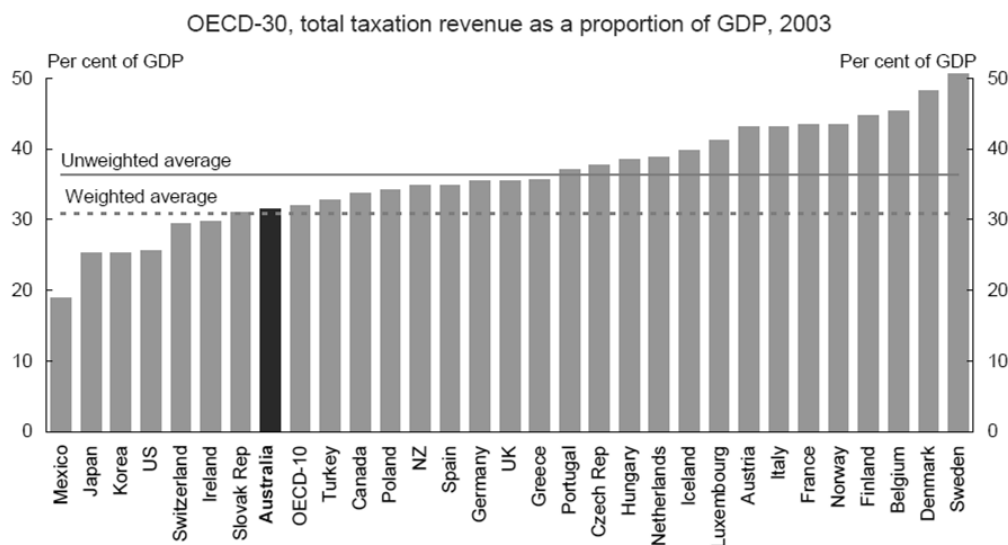
A major review of the taxation system (The Henry Review) was conducted in 2009 and the report (AFTS Secretariat, 2010) provides a wealth of information on how the Australian taxation system compares internationally (Australia's Future Tax System, 2008). The metrics in these comparisons are generally prior to impacts of the GFC:

- Australia can be considered a low tax country by developed country standards (see Figure 10). However our tax to GDP ratio is above that of our immediate neighbours, reflecting the greater role of government in our economy, and raising questions as to impacts on competitiveness.
- Australia had a similar mix of direct and indirect taxation to other OECD countries, with the major differences being that we do not levy a social security tax, have a dividend imputation system, have a generally lower reliance on broad-based

consumption taxes (see Figure 11) and a higher reliance on revenue from taxes on property (see Figure 12).

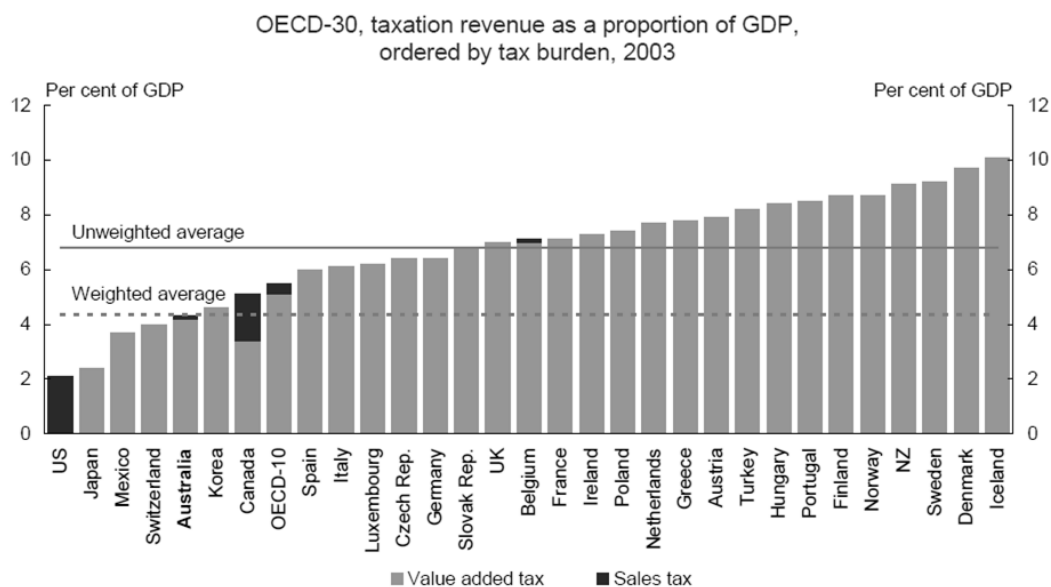
- Australia had a top personal income tax rate that is typical of most developed economies in the OECD, but as noted there is no social security tax – with a consequent high tax burden on capital income, taking into account differences in capital tax settings.
- The tax mix was slightly skewed toward direct taxes on labour income (around 40 per cent of tax revenue). Taxes on capital income account for about 33 per cent, while taxes on consumption account for 27 per cent.
- Australia’s corporate tax rate was relatively high (eighth highest in the OECD) and corporate tax revenue as a percentage of GDP is the fourth highest in the OECD.
- Australia’s taxes on fuel were low in comparison to other OECD countries.
- Australia’s tax-transfer system was highly redistributive by OECD standards.

**FIGURE 10: AUSTRALIA’S RELATIVE TAX BURDEN, OECD-30, 2003**



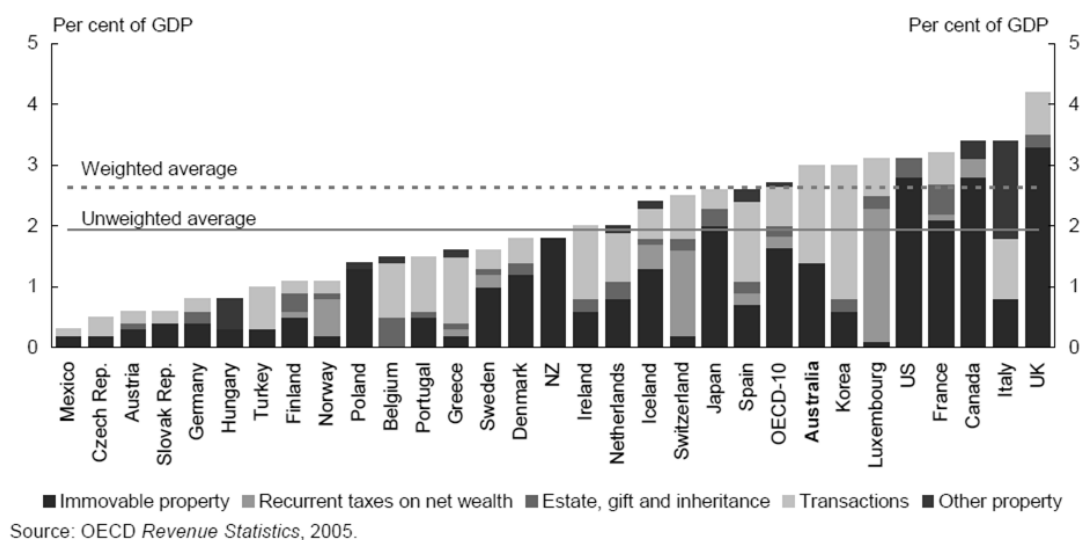
Source: Australia’s Future Tax System

**FIGURE 11: VALUE ADDED AND SALES TAX BURDEN, OECD-30, 2003**



Source: Australia’s Future Tax System

**FIGURE 12: PROPERTY TAX BURDEN, OECD-30, 2003**



Source: Australia’s Future Tax System

The revenue raising system is heavily skewed to the Commonwealth Government – it raises 80% of taxation revenue, while the States raise 17% and Local Government 3%. The Henry Review (2009) notes that despite this imbalance, the State taxation take is quite significant, and recommends it should remain so, in that:

*For as long as the States have significant expenditure responsibilities, they should have access to significant and sustainable tax revenue. Furthermore, the States should also have some autonomy over the amount of tax revenue they raise, so they are accountable for their expenditure decisions” (p 70).*

State and Local Government’s own purpose revenues make up around 16% of GDP – with the major sources being payroll tax, land and property taxes (including stamp duties as a transaction tax on the transfer of land) and gambling taxes. Own purpose revenue fell with the introduction of the GST and revenues from this source are collected by the Commonwealth and ‘granted’ back to the states (with an equalisation framework used).

**TABLE 3: CHARACTERISTICS OF STATE AND LOCAL GOVERNMENT REVENUE BASES, AUSTRALIA**

Revenue	Propn of GSP/ GDP (2011-12)	Annual Growth rate (decade)	\$ per capita (2011-12)	Real Annual Growth (decade)
Taxation revenue	4.9%	-1.0%	3,289	1.6%
Current grants and subsidies	6.0%	-0.9%	4,015	1.7%
Sales of goods and services	1.9%	-0.2%	1,280	2.4%
Interest income	0.4%	3.3%	240	5.9%
Other	2.7%	4.2%	1,790	6.8%
Total Revenue	16.0%	-0.1%	10,614	2.5%

Source: Calculations based on ABS Catalogues 5512 (2010-11), 5519 (Sept Qtr 2012). 5220

With respect to taxation revenues, public finance theory identifies the following as the core principles for reviewing taxation mechanisms:

- **Allocative efficiency** – taxation systems should not unduly distort consumer choice (implying that taxation should be based on products with low elasticity).

- **Transactional efficiency** – the method of collecting funding and taxation revenues should have a low administrative burden. In a dynamic context, a high-quality revenue system produces revenue in a reliable manner. Reliability involves stability, certainty and sufficiency.
- **Equity** - A high-quality revenue system treats individuals equitably. Minimum requirements of an equitable system are that it imposes similar tax burdens on people in similar circumstances, that it minimizes regressivity, and that it minimizes taxes on low-income individuals.

As part of the discussion around allocative efficiency, we need to be aware that there can be a distinction between who nominally pays the tax and who actually pays the tax – which is called the economic incidence of the tax. In general, it is concluded that whether it is a tax on consumption OR a tax on production if elasticity of demand is less than elasticity of supply the consumer bears the bulk of the incidence. However, if demand is more elastic than supply, then the supplier bears the incidence. In the short run, for many products supply is relatively inelastic while in the long run it becomes more elastic. Further, the more elastic the demand, the greater the social or welfare loss (that is a tax allocated on a product that is price elastic has a greater distortionary effect on the consumption of the good or service being taxed) - regardless of who carries the incidence.

## 5.2 HENRY REVIEW

As a general summary, the Henry Review assessed the structure of the Australian Tax System and developed recommendations for the Government to consider. These recommendations were heavily predicated on growth in demand for health and aged care services, mostly based on demographic pressures (though acknowledging expectations).

The Review concluded that the tax system was over-complicated (with 125 different taxes, while the 10 largest taxes contributed 90% of revenue<sup>8</sup>). The Review suggested that the system needed to be simplified and needed substantial reform to deal with the complex world Australia would be facing into the future – and specifically the additional revenue that would be needed to provide services. It included 138 recommendations for moving forward, recommendations which to this point have been generally ignored. The political experience of the last few years is indicative of how difficult it is to achieve even minor tax changes – and this constrains the opportunities to move forward.

In an overall context the recommendations involved simplifying the system substantially, reducing income taxes and taxes on investment (as taxes that were inefficient in an economic sense), while increasing resources and land taxes. The mining tax was really the only one of those that has been tried, and even then in a watered down version than that envisaged by Henry, and now with a change of government the mining tax has been removed.

Specific recommendations with implications for health services included:

- **Recommendation 5:** The Medicare levy and structural tax offsets — the low income, senior Australians, pensioner and beneficiary tax offsets — should be removed as separate components of the system and incorporated into the personal income tax rates scale. If a health levy is to be retained, it could be applied as a proportion of the net tax payable by an individual.
- **Recommendation 7:** Consistent with recommendations by the National Health and Hospitals Reform Commission:
  - a) The medical expenses tax offset should be removed following a review of the scope and structure of health safety net arrangements.

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<sup>8</sup> These are in descending order personal income tax, company tax, GST, payroll tax, fuel excise, local government rates, conveyance stamp duty, superannuation taxes, tax on tobacco and land taxes. Indeed the first three of these make up 70% of the total revenue base.



- b) The Medicare levy surcharge and assistance for private health insurance should be reviewed as part of the package of tax and non-tax policies relating to private health insurance. The Medicare levy surcharge lump sum payment in arrears tax offset should be retained if the Medicare levy surcharge is retained. Assistance, if retained, for private health insurance should be provided exclusively as a direct premium reduction.
- **Recommendation 109:** There is considerable scope to align aged care assistance with the principles of user-directed funding to provide assistance in line with recipients’ needs, enable their choice of care and support the fiscal sustainability of the aged care sector. However, effective user-directed funding is significantly limited by regulations that govern supply and price, reforms to which would have complex sequencing and transition issues.

In addition the review advocated increased use of user charging, saying “user charging can be an efficient means of financing some government-provided goods and services and of rationing individual access to community resources” and “Australian governments do not employ user charging as much as they should”. Interestingly they suggest “For user charging to be efficient, the user needs to be charged the cost that consuming the good or service imposes on others. This cost will often be what a well-functioning market would charge, but might need to be higher or lower depending on whether there are wider social costs or benefits” (AFTS Secretariat, 2010, p. 325) noting that rivalry and excludability are the core concepts for determining the right price. The report specifically advocates for user charging (either full or partial) in the health care sector stating that “a mixture of charging arrangements is appropriate as health care can be considered to be a public, private or merit good”.

**TABLE 4: IMPLICATIONS OF RIVALRY AND EXCLUDABILITY ON PUBLIC FUNDING MIX**

	Rival in consumption	Non-rival in consumption
Excludable	Private good e.g. apples [user charge]	Club good e.g. agricultural levies [beneficiary taxation]
Non-excludable	Common pool resource e.g. fisheries, forests [user charge]	Public good e.g. national defence [general tax or corrective tax/regulation]

Source: (AFTS Secretariat, 2010, p. 328)

Discussion on taxing alcohol and tobacco in the report covers the implications of alcohol abuse on health care costs (i.e. this and other negative outcomes).

The Review also looked at specific taxes that are seen as gaps in the taxation landscape including:

#### BEQUEST TAXES

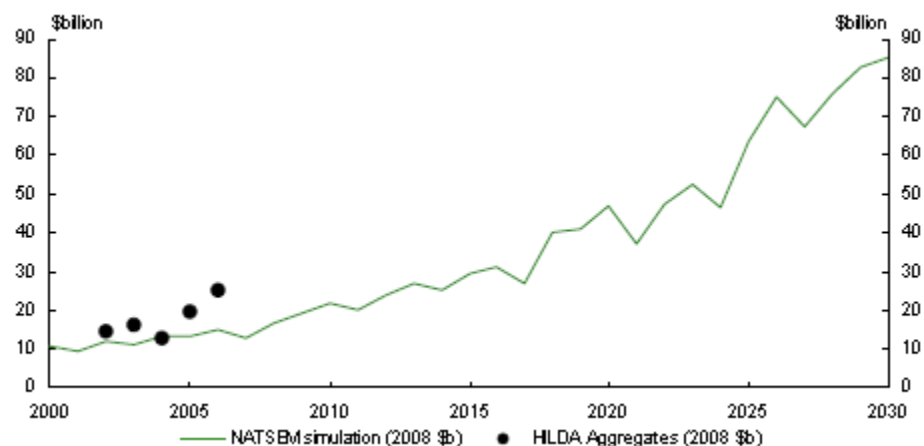
In relation to a bequest tax the Henry Review stated, “The Review has not sought to recommend the introduction of a bequest tax at this time, but believes that there should be full community discussion and consultation on the options” (AFTS Secretariat, 2010, p. 137) and indicates the following in favour of a bequest tax.

- It is a relatively efficient means of taxing savings in that it does not introduce large biases.
- It has opportunities to be progressive in nature.
- It fits well with demographic circumstances as the wealth held by older Australians is predicted to increase substantially.

- There is precedent, both historically and in other countries (with on average OECD countries raising 0.41% of total tax revenue from bequest type taxes).

The Henry Review suggests that any tax should be at a relatively low rate (to minimise incentives and distortions) and notes the prime disadvantage as being that it is administratively complex, and it would overlap with some elements of the existing taxation system.

**FIGURE 13: PROJECTED BEQUESTS, AUSTRALIA, 2000-2030**



Source: (AFTS Secretariat, 2010, p. 142)

## TAXES ON FINANCIAL SERVICES

The review suggested that the current way GST works with respect to financial services is inefficient, and suggests a financial services tax could be used to ‘replace’ GST input taxation.

It addressed specifically the suggestion of what is called a ‘Tobin tax’ (which is also called a ‘Robin Hood tax’) – a tax on currency transactions. When initially proposed, it was in relation to foreign currency transactions. Proposals developed were more broadly based and suggested taxing financial services on a turnover basis. One of the strongest proponents in Australia, Professor Ross Buckley, argues that it is necessary to fix market failures in financial markets and claims that:

*Carefully calibrated legal and tax responses are required to change market behaviour. Such a tax as part of an integrated policy framework would reduce short-term momentum trading and promote longer-term investment that would better reflect underlying economic fundamentals (Buckley & North, 2012)*

The arguments generally in favour are that it reduces financial instability, by limiting speculation; and that it potentially raises large amounts with a very small rate. The Henry Review rejected this option in that:

- It is inconsistent with other forms of consumption tax.
- It is inefficient, as the tax rate rises on the number of transactions (how often an asset changes hands) rather than any real economic value.
- It could promote financial instability by reducing market liquidity and constraining hedging activity.
- It would be difficult to regulate – with activity switching to unregulated sectors, and would promote business structures based on minimising the tax.

### 5.3 PRODUCTIVITY COMMISSION – USER CHARGES

A Productivity Commission review of public infrastructure provision noted that regardless of how infrastructure is financed, funding must come from “payments for the provision of services through market-based prices (determined by consumers and providers and possibly supervised by regulators), taxes on beneficiaries, general taxation sources, and occasionally from philanthropy” (Productivity Commission, 2014, p. 11). The conclusion is that “well-designed user charges should be used to the fullest extent that can be economically justified” (Productivity Commission, 2014, p. 2), arguing that efficient user charges are superior to taxes in many situations, and are an effective means to reveal willingness to pay for new infrastructure.

Similarly the Productivity Commission aged care inquiry, in noting the need for improved quality and access for aged care, concluded that user charges will have a significant role, and that older Australians would “contribute, in part, to their costs of care (with a maximum lifetime limit) and meet their accommodation and living expenses (with safety nets for those of limited means)” (Productivity Commission, 2011, p. XVIII).

A third report by the Productivity Commission continues this trend – it recommends that roads, traditionally government funded, should increasingly apply user charges, in that “Developments in road pricing technology create the opportunity for more cost reflective pricing which, combined with institutional changes to link road supply and demand, offer the potential for substantial efficiency gains” (Productivity Commission, 2006, p. XXVI).

What is clear from these inquiries, is that all have a theme of recommending user pays (within limits), even more strongly than Henry, but consistent with broad policy directions. The current policy environment is really pushing for increased user pays.

### 5.4 INDEPENDENT AUDIT COMMISSION

The Audit Commission reported that “Health care spending represents the Commonwealth’s single largest long-run fiscal challenge, with expenditure on all major health programmes expected to grow strongly to 2023-24” (Commonwealth of Australia, 2014, p. 95).

Broad areas of reform proposed include:

1. Requiring those on higher incomes to take greater responsibility for their own health care needs – requiring them to have PHI, moving some services currently covered by Medicare over to PHI, increasing the Medicare surcharge (recommended to 3.5%).
2. Requiring everyone to make a small contribution to the costs of their own health care – through the introduction of the highly controversial co-payment scheme – applied to doctor and hospital visits and not covered by PHI.
3. Improving the effectiveness of private health insurance arrangements deregulating price setting arrangements, allowing health funds to expand their coverage to primary care settings, relaxing community-rating to allow health funds to vary premiums to account for a limited number of lifestyle factors, including smoking; and reforming the arrangements by which insurers equalise risks through the sector.
4. Improving the effectiveness of Medicare - reviewing the Medicare Benefits Schedule to identify and remove ineffective items, replacing expensive items with less expensive alternatives where available and investigating options for cost recovery for applications to list items on the Schedule.
5. Improving arrangements with the States – with the major thrust being reducing the amount of the Commonwealth contribution, but reducing reporting requirements – which of course is not seen by all (or many) as improving the arrangements.

It also recommends introduction of major new arrangements for the Pharmaceutical Benefits Scheme – which again increases the level of co-payments.

In more general terms the Commission of Audit recommended:

- Creating a more effective Federation, involving:
  - Reducing duplication in involvement and role; and
  - Reallocating revenue responsibilities to better match spending responsibilities – with the recommendation that States and Territories have access to the personal income tax base (while reducing the Commonwealth rate). Further they recommended that GST be distributed without equalisation (and the equalisation process be replaced by a grant).
- Reducing (or slowing) the no policy change growth of a range of government expenditures.
- Rationalising and streamlining government bodies.
- Improving operational efficiency, through appropriate adoption of technology on the one hand and through increasing the degree of market signals used to ration demand on the other.

The recommendations of the Commission have been partially brought into play in the 2014/15 budget, with many items still the subject of public debate.

## 6 POSSIBLE FUTURE DIRECTIONS FOR AUSTRALIAN HEALTH CARE FUNDING

### 6.1 GENERAL DISCUSSION OF OPTIONS

Based on the literature and the evidence presented above, and the current political landscape, four key domains for considering funding options for health care and health are presented.

#### 6.1.1 DOMAIN 1 – IMPROVED EFFICIENCY IN SERVICE DELIVERY

While most expect that demands on the health sector will increase, opinions differ about how these demands might be met. Increased funding is of course one option, as is funding to improve the effectiveness of the system. The latter includes changing consumer practice (health risk prevention), directing demand to more cost effective (but appropriate) levels of service, introducing cost saving technologies and so on. Improving effectiveness requires enhanced management systems in existing entities and appropriate de- or re-regulation of the sector to enable the implementation of practices that produce better outcomes while using equivalent resources.

However, it should be understood that:

- Productivity enhancing reforms require funding and finance – funds for research, financing options for new equipment (new technology can in the short run increase costs, though in the long run should improve productivity and outcomes), funding of training and systems improvement.
- There is a link to the incentives created from Domains 2 to 4. Funding structures need to be cognisant of a strategy to improve effectiveness rather than embed current practice. A large part of the argument for a push towards user pays is that in itself this creates more of an incentive to encourage more effective usage.

Improving effectiveness requires:

- Improved management systems in existing entities.
- The implementation of appropriate de- or re-regulation of the sector to enable practices that produce outcomes that can be better delivered.

#### 6.1.2 DOMAIN 2 – THE MIX BETWEEN PUBLIC AND PRIVATE FUNDING

The public good/merit good arguments of health service provision are undeniable. The provision of universally accessible and high quality health services necessarily requires significant public funding. Competition for public funding has, however, intensified at the same time as the demand for health services is growing. As a consequence health agencies are under greater pressure to contain costs. Meanwhile policymakers have sought to move more people from reliance on the public health system to the heavily subsidised private system.

Australia already has a greater reliance on private funding than most countries, and over-reliance on private funding involves structural market failure issues. It also has significant implications for access and the equity, exposing low income households to an increasingly residualised public system and a prohibitively expensive private system. It is clear that current safety net responses (particularly in terms of the reliance on Private Health Insurance) do not adequately address this. In short, substantially shifting the burden away from public funding would be expected on the evidence to introduce more problems than it would solve. The USA is, of the developed economies, a system that relies the most markedly on private funding for health care (see Figure 6 above). And yet consistent reviews suggest that despite the much larger total spend on health care (see Figure 5),

the system delivers generally at the lower end of quality. Davis et al (2014) conclude that despite the per capita health spend in the US being double that of other countries, the system ranked 11<sup>th</sup> out of 11 countries reviewed, and performed especially poorly with respect to efficiency, equity and cost<sup>9</sup>. Drosler et al (2009) indicate that the USA is at the upper end of 19 countries in terms of poor patient safety indicators during stays in public hospitals. Clearly having private users fund more of the health care system neither saves money, nor does it result in better outcomes. Koechiokn et al (Koechin, Lorenzoni, & Shreyer, 2010) also indicate that the US hospital system is markedly more expensive than other countries, both to individuals and to the health care system overall.

With respect to quality outcomes – access to effective health care by socially disadvantaged groups in an expensive system becomes more problematic. As noted above, lower income households spend a greater proportion of their income on health and medical expenses, with 6.9% of income spent by the lowest quintile compared to 5% in the highest quintile. While, the lowest quintile spend 43% greater than the average household on specialist health practitioner fee's but 8% less for general practitioners – suggesting that their burden is reduced by access to bulk-billing. The lowest income group spends almost double the proportion of their income on prescription medicines, and almost triple the rate on hospitals and nursing homes. This is partly explained by the large proportion of aged households in the low income group, but not entirely. Due recognition also needs to be given to the fact that lack of information and decision making ability may result in income restricted individuals making choices that carry greater cost in the long run (e.g. deferring treatment until the illness becomes more severe, mothers and fathers putting their children's health as a priority above their own).

### 6.1.3 DOMAIN 3 – INCREASING THE USE OF TAX REVENUE

Taxation revenue available to fund health services can be increased by one of two means:

- Redirecting from other public expenditure items; and/or
- Increased taxation revenue opportunities.

Reviewing the priorities and efficiency in terms of use of public funds is usually the first action of every newly elected government, and Australia saw the same approach at the beginning of the Abbott Government's term with the Commission of Audit. Their recommendations as to the possible source of savings (or preventing cost blow outs) singled out 15 major programs with the major items as follows, and identified a range of other areas:

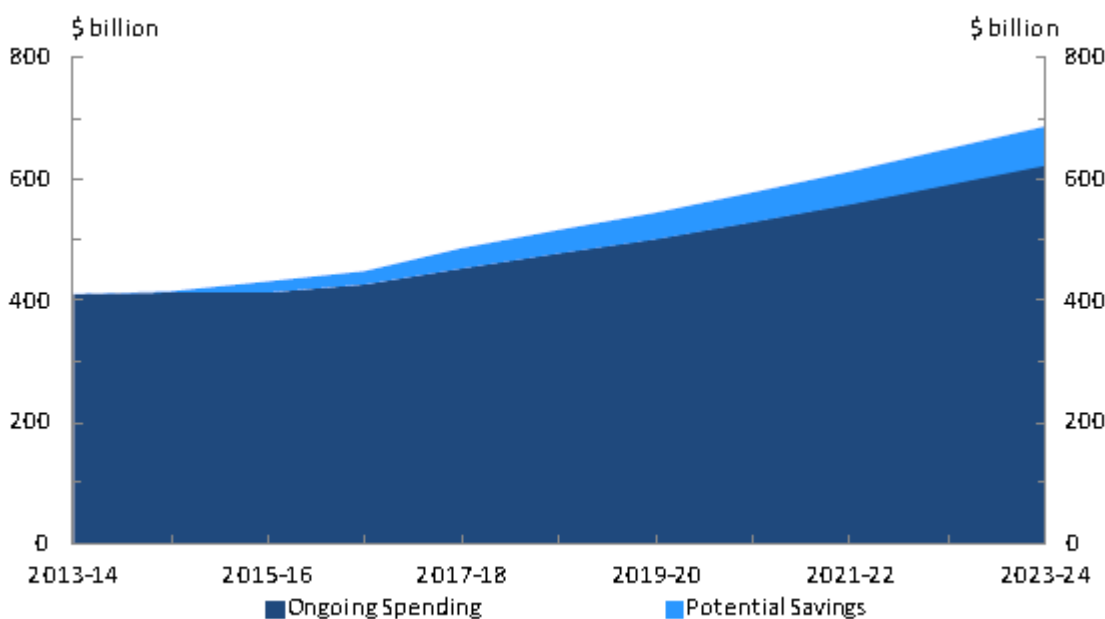
- Reducing foregone income (e.g. family tax benefits),
- Tightening eligibility rules on a range of programs, including the age pension,
- Reducing available funds for some programs (e.g. ABC and SBS, industry assistance programs and funding for industry specific research programs), and
- Abolishing specific programs.

They suggest the combination of recommendations will save in the order of \$100 billion annually by 2020.

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<sup>9</sup> Note that Australia came in 4<sup>th</sup> in terms of overall ranking, despite being at the lower end of per capita expenditure for this group of countries

FIGURE 14: POTENTIAL SAVINGS FROM THE COMMISSION OF AUDIT’S RECOMMENDATIONS



Source: (Commonwealth of Australia, 2014, p. xxx)

Again as noted above, the Commission also had a strong focus on reducing health care expenditure – so the recommendations above were about reducing expenditure overall, not in terms of transferring expenditure from one item to another.

Australia is a middle level taxing nation less reliant on broad based consumption tax and more reliant on income tax (particularly company tax). A conclusion that can be reached is that there should be an increase in the GST (both by broadening the base and increasing the rate). A 1% increase in the rate of GST would raise over \$4 billion of new revenue based on current consumption levels. While this would have advantages with respect to economic and administrative efficiency, the distributional impacts of the GST are problematic. Low income earners pay a greater proportion of their income in GST than higher income earners. As such, increasing the rate of the GST would need recognition within the social net, which would offset the administrative efficiency argument.

The other major or broad level options for increasing tax revenues include:

- Increasing the income tax rate,
- Increasing the Medicare Levy AND targeting the increase in funds towards health,
- Removing or reducing income tax deductions or rebates,
- Increasing taxes on a range of goods and products (e.g. petroleum levies, resource rent taxes), and
- Increasing taxes on products that have a specific linkage with health outcomes (i.e. target public ‘bads’, such as alcohol and tobacco, fast food) and allocate the extra revenue to the major impacted sector - the health system.

All of these types of action are discussed in the Henry Review, and in other policy documents. The constraints with respect to these items include:

- Significant increases in any specific item would effectively require broad scale reform to reduce the inefficiencies they would introduce.
- Specific levies (including Medicare, the Emergency Services Levy) have historically been introduced based on an observed ‘need’ but in practice are generally not tied to specific expenditure programs, and as such are often treated by the population with

scepticism. The Henry Review recommends removing the Medicare levy and building this into the income tax rate (and a consistent outcome for the Emergency Services Levy would be to build it into Land Taxes – or specifically Council Rates) and as long as the rate is well below what is needed to cover expenditure this would be valid. There would, however, be some argument to significantly increase the levy so that revenues more closely match expenditure, and even to tie it to expenditure – and at the aggregate level people would see that improved sector efficiency (including demand management) can reduce this tax.

- Removing rebates will generally not significantly increase funding, as they are based on a safety net argument, and they will need to be replaced by alternatives. The aim of removing rebates is to increase efficiency and signals.
- There is an issue with relying on revenue from public ‘bads’ in that the desire is to, over time, reduce the extent of the bad, which will in term reduce the amount of revenue.

In recent months, business sector representatives and the recently released Financial System Inquiry called for the removal of dividend imputation and negative gearing, and the revamping of the capital gains tax<sup>10</sup>. Arguments have been based around claims that these taxation measures bias investor choices. However, as with all arguments there are competing drivers, and complexities that make reform difficult. The Henry Review also considered these issues and generally indicated that (although longer term changes would still be required) in the short run they should be left substantially the same (or indeed in some cases such as capital gains they should be modified and broadened) as they did not offer a large source of extra taxation revenue.

#### 6.1.4 DOMAIN 4 – EFFECTIVE USER PAYS

Where increased user pays is implemented it needs to be designed in such a way as to be effective, and to not just be seen as extracting more money, but also to be effective in driving sensible behaviours (i.e. creating the right incentives). In addition the complications are that:

- The level of funding needs to recognise the extent of private benefit involved, and charging over this level will result in perverse health outcomes.
- While the Commission of Audit says that “reducing government expenditure as well as red tape and compliance costs will open opportunities for the private sector” the implication is that this does not *per se* reducing the pressure of rising health care costs – rather it is just transferring who pays for it from the government purse to the private purse.
- Consumers will have to make choices about what they purchase from a limited budget – and in an environment where there is a significant push to user pays this will place (jointly) significant pressures on the household purse. This is discussed above – and the implications of reduced access for lower income groups and the incentive to make health negating (e.g. avoiding preventative health actions) long term decisions (in the absence of information, or access to funds) must be considered.
- For user pays to improve demand management (reducing excess demand, and using prices to ensure health service consumers think about the value in using the service), this will only be effective if there are minimal market failures on the supply side, or if the regulatory framework is itself effective. Otherwise the burden is simply transferred, or the evidence suggests the costs of the system will increase.

The Commission of Audit (and current budget policy) has an extensive focus on increasing user pays, through:

<sup>10</sup>

See for example:

- ABC News, 7<sup>th</sup> Nov 2014, “Economists say Government should scrap negative gearing tax break to potentially save \$5 billion”
- The Australian Business Review, Dec 8<sup>th</sup> 2014, “Murray Inquiry: Negative gearing, dividends and capital gains targets”



- Increased co-payment for doctor's visits and for hospital visits and medicines (noting that the budget proposal is significantly less than that suggested by the Commission of Audit).
- Removing items from the Medicare Benefits Schedule.

In addition to issues raised above, some of the commonly expressed concerns with respect to co-payments are related to administrative complexity, which have actually been made worse under the revised proposal, and include:

- The additional administrative task for GP's (now sorting out eligibility versus ineligibility for bulk billing)
- The pressure on the doctor in 'choosing' to require a co-payment
- The waste of resources in game playing as people try to find arbitrage opportunities in the complex system (e.g. the possible use of hospital emergencies for non emergency uses – which depends on State Government reaction in terms of charges in this context).

The combination of reports all focus on structural change as necessary to ensure the push to user pays is successful in achieving the desired outcomes (rather than just increasing the overall cost of health care or transferring the burden). This includes:

- Ensuring changes to the Private Health Insurance market to act as an effective safety net, but to reduce moral hazard and other market failure outcomes.
- Increased competition in markets – including:
  - Use of professionals in roles they currently are precluded from (e.g. nurses or chemists being able to perform roles in the system currently limited to doctors), and
  - Increasing access more generally.

### 6.1.5 DISCUSSION OF SPECIFIC OPTIONS

Possible alternative revenue options for consideration under the brief for this paper included:

#### **Bequest (on estate) tax:**

Bequest taxes are taxes on inheritances, or on transfer of assets. There is no such direct tax in Australia, whereas most other countries have some form of a bequest tax (generally at low rates). A bequest tax rate of 1% would raise an estimated \$250 million in 2015, rising to \$400 million by 2020 and \$800 million by 2030. This form of tax was generally supported as being efficient in the Henry Review. In general terms it also is favourable in terms of equity implications. The biggest issues are avoidance behaviours that might be induced, administration costs and potential issues in valuation and liquidity of certain types of assets.

#### **Private health insurance subsidies:**

Abolishing subsidies for private health insurance would increase taxation revenues by approximately \$6 billion per annum, and abolishing the rebate for higher income earners would save further amounts. This is consistent with the recommendations of the Henry Review. The rebate reduces the amount you pay for private health insurance. The rebate amount you get is based on the age of the oldest person covered by the policy and by annual earnings.

The amount of rebate is tiered, with the base tier involving single incomes up \$90,000, Tier 1 up to \$105,000, Tier 2 up to \$140,000 and Tier 3 beyond that. Family and couple incomes are double that amount. The thresholds are increased each year, based on growth in average weekly earnings.

Given the equity implications, and as observed earlier, the fact that people on lower incomes are less likely to have PHI, careful consideration would need to be given to

removing the rebate structure altogether. However, consideration could be given to reducing the tier cutoffs, and reducing the rate of rebate at higher income levels. This would, however, reduce the amount of funding raised.

#### **Medicare Levy:**

The Medicare Levy currently raises \$14 billion after the recent increase in rate to 2%. An increase by a further 0.5% raises an additional \$3 billion per annum. To do so ignores the recommendations of the Henry Review to morph it into general income taxation. Further, more radical reform of specifically funding public health care costs through a significantly increased Medicare levy are also possible, to increase it (with 'almost offsetting' reduction in income taxes) and tie it to the level of health expenditure.

#### **Mineral Resource Rent Tax:**

Implementation of the original Henry Review recommendations relating to the taxation of resources and land were estimated to lead to a gain to revenue of around \$7 billion in 2010–11 values, when fully mature. These recommendations were not implemented, and the minerals tax that was implemented failed to raise this level of funding. However the arguments of Henry remain valid, and represent an effective opportunity to revisit the debate around this source of tax revenue.

#### **A 'Robin Hood' Tax**

The concept of a tax on financial transactions has been mooted as a possible option for addressing the needs for an increase in tax – sometimes called a 'Tobin' tax or a 'Robin Hood' tax. The idea was considered by Henry, but rejected for a range of reasons. While how much it would raise is heavily dependent on the definition applied to transactions, one of the attractions is that it would raise a large amount of money for a small imposed rate, and secondly that it can be considered a progressive tax in that people with greater wealth will undertake larger and more frequent transactions. Ross Buckley is one of the major proponents of this tax and is reported as estimating that a 0.05% FTT collected on Australian 'over-the-counter' and exchange-traded market transactions between 2005-06 and 2008-09 would have raised \$48 billion – an average of \$16 billion each year.

While proposed in the aftermath of the GFC in Europe (by Tobin) it has not been extensively (or consistently) introduced – but it is still promoted widely in the policy debate.

#### **State Health levy:**

States could increase their direct funding of health services, with for example a health levy on households (as an additional payment within the emergency services levy framework). A levy on households in SA (approximately 650,000 households) of \$100 per household would raise \$65 million a year. This would need to be introduced with safety net considerations. Further there are equity issues, particularly in the context of the aged population where older people can be asset rich (through the family home – on which the levy is based) but income poor. This issue is already a concern in terms of the payment of council rates, with an observation that a wealth based tax on a liquid asset can create unintended pressures where incomes are low (for example in the retired population).

Table 5 provides an overview of the possible options to enhance the funding base for health services in Australia. It includes an indicative rating under the core categories of economic efficiency (induces appropriate allocation of resources), equity implications, and provides summary comments on other aspects of the funding mechanism.

**TABLE 5: SUMMARY OF OPTIONS TO ENHANCE THE FUNDING BASE FOR HEALTH SERVICES IN AUSTRALIA**

Indicative ratings with respect to the implications of the given funding mechanisms in terms of the key attributes of a funding system have been included. These are a matter of judgement and not quantitatively derived, and are dependent on the details of discussion in the document. The rating scale is from 1 (very poor) to 5 (very good)

	Revenue Capacity	Equity Rating	Efficiency Rating	Transparency Rating	Administration	Precedent	Increase tax avoidance	Other
<b>Bequest tax</b>	1% rate ⇨ \$400m by 2020	4	4	4	Complex, some overlap with existing tax system	Average 0.41% of tax revenue in OECD countries	✓	
<b>Abolish PHI subsidies</b>	\$ up to 6 billion (if fully retracted)	2	3	4	Henry Review advocates this as simpler, but also would require alternative systems to deal with equity implications			May result in people 'opting out' and putting more burden on public health system
<b>Increase Medicare levy</b>	0.5% increase in rate ⇨ \$3 billion	2	2	2	Simple as based on existing system, but simpler if included in income tax rate	Sits within context of a high proportion of tax revenue collected from income tax in Australia		While described as a Medicare levy the current system does not cover the MBS costs, and is not really tied. It is a general levy
<b>Mineral Resource Rent Tax</b>		5	4	3	Overlap with state taxation systems	State levies and international practice		Politically difficult in current environment, needs to be set around resource rents
<b>FTT or 'Robin Hood' Tax</b>	0.05% rate ⇨ \$16 billion	5	2	4	Difficult to regulate	Proposed in aftermath of GFC in Europe, but not implemented	✓	
<b>State Health Levy</b>	\$100 rate per household ⇨ \$65m in SA	3	2	4	Tie on to existing systems	Emergency Service Levy		

Note that these calculations of revenue dependent are based on simple relationships, and it is possible that the introduction of such an action would impact behaviours in such a way as to limit the outcome. More complex modelling would be required in each case for a more precise estimate.

## 6.2 SUMMARY OF OPTIONS

In summary the following revenue options might be considered (taking into account the issues of detail raised in the discussion):

1. Increase the rate of the GST to 11%, and broaden its base – without any offset in income tax rates – and transparently direct the funding to health services.
2. Introduce a Federal bequest tax of 0.5%, again with the funding raised transparently directed to the provision of health services.
3. Introduce a Financial Transactions Tax at 0.05%, with the funding raised transparently directed to the provision of health services
4. The Commonwealth revisit aspects of the Henry Review, and specifically:
  - a. Remove rebates and subsidies in the public health system, and
  - b. Design and implement an effective and workable resources tax.
5. Increasing the Medicare Levy, and matching and tying it to the expenditure needs of the health sector (after agreed reforms).
6. Undertaking a comprehensive review of the way that Health Services are managed and delivered to maximise efficiency and effectiveness while maintaining universal standards of health care service delivery.

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