Australian Nursing & Midwifery Federation

Submission to the Senate Community Affairs References Committee Inquiry into Out-of-Pocket Costs in Australian Healthcare.

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Introduction

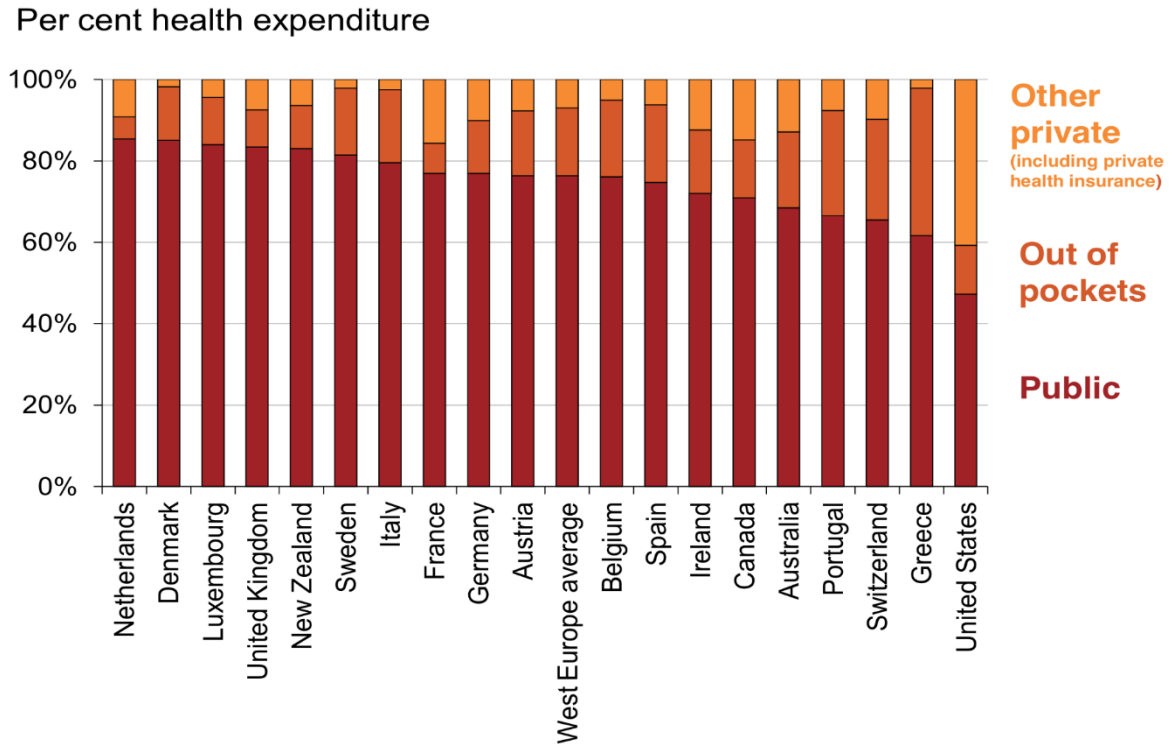
Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership of over 230,000 nurses, midwives and assistants in nursing, our members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private health and aged care sectors.

The ANMF participates in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

A. CURRENT AND FUTURE TRENDS IN OUT-OF-POCKET EXPENDITURE BY AUSTRALIAN HEALTH CONSUMERS.

Australians have a high rate of out-of-pocket expenses by world standards. Among Western economies, only Portugal, Greece and Switzerland have a higher percentage of expenditure on out-of-pocket health expenses. Australian's out-of-pocket health expenditure is comparable to Italy, Spain and Belgium, while we have a much higher percentage of expenditure on out-of-pocket health expenses than the USA, the UK, New Zealand and the average expenditure across Western Europe. [1]



Source: Grattan Institute *Is Medicare sustainable? and, Is the question helpful or not?* AHHA Roundtable Jan 2014.

[1] Duckett, S. Grattan Institute Is Medicare sustainable? and, Is the question helpful or not? AHHA Roundtable Jan 2014.

Australians have a better than average life-expectancy, while Government, using taxpayer funds, spends less on health care per person compared to other OECD countries[2].

> *"What we spend on GDP sits about in the average for developed countries and we have dramatically better health outcomes than many other countries including countries that spend more".*[3]

Australians have a higher life expectancy than many of our OECD counterparts because of a universally accessible health system which has been underpinned by Medicare for the last 30 years. Everyone who can pay a contribution does so through their taxes. Those who earn more pay more. Those who earn less pay less, but everyone pays the same proportionally. Australians pay for their use of the public health service. It is not free. Health care is not delivered for free as has been asserted by the coalition Government and its advisors, since it came to power in 2013. Rather, the health system is funded by taxpayers.

Medicare has served the Australian community well, providing the fundamentals of a sound health system – access, equity and quality outcomes.

Over the decade from 2000 to 2011, the Australian health system experienced an average 2.5% increase per year in the number of Medicare Benefits Schedule (MBS) services provided, and an average 7.5% increase per year in the total benefits paid. Besides the Medicare and Disability levies, Australians are contributing a significant out-of-pocket sum, the share of which also increased over this decade. Out-of-pocket expenses for Australians are higher than most other OECD countries[4].

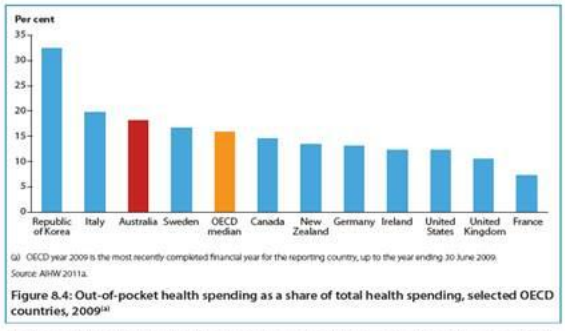


Figure 8.4: Out-of-pocket health spending as a share of total health spending, selected OECD countries, 2009[(a)]

As a share of total household spending, Australia's out-of-pocket payments for health rose from 2.4% to 2.8% over the decade. The OECD weighted average rose from 2.7% to 2.9% over the same period (AIHW 2011a; OECD 2011).

In 2009-10, the non-government sector provided 30% ($36.6 billion) of funding for total spending on health goods and services, 58% of which came from out-of-pocket payments by individuals – funding almost half (47%, or $7.7 billion) of spending on medicines, and 61%, or $4.7 billion, of total spending on dental services (AIHW, 2012:475). These out-of-pocket expenses paid by individuals are additional to the health insurance premiums and the Medicare levies they have already paid.

Healthcare in Australia is paid for by the community on multiple levels and occasions. While improvements need to be made, Medicare has been the cornerstone of a system that has been able to deliver some of the best health care outcomes in the world.

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[2] Duckett, S. *Needed reform in health care*, in *Health Voices Journal of the Consumers Health Forum of Australia*. Issue 14, April 2014 pp. 9-10.

[3] Dr Lesley Russell, (Menzies Foundation Fellow at the Menzies Centre for Health Policy at the University of Sydney and ANU and a Research Associate at the US Studies Centre) Speaking on *The World Today* ABC Radio National. 2 May 2014

[4] Australian Institute of Health and Welfare. Australia's Health 2012. Canberra: AIHW, 2012. Pp. 475-6

We need to revisit the foundations of Medicare to understand that our healthcare system is based on universal responsiveness to health needs regardless of financial means. When we understand the true values underpinning Medicare, we understand how the most vulnerable and disadvantaged people in our society are burdened by the current flaws in the system, including out-of-pocket costs. The Australian Nursing and Midwifery Federation (ANMF) maintains poor decision-making by governments in regard to health care directions will lead to much greater disadvantage than already exists.

Our concerns about access and equity are shared and have been raised by a wide range of health care professionals and social and economic commentators, including the Australian Medical Association, the Consumers Health Forum of Australia, the Australia Institute and the Grattan Institute.

The ANMF contends the estimated offset through a co-payment to Medicare for GP services will lead to compromised healthcare outcomes, increased emergency department presentations and hospital admissions. The legacy will be a healthcare system that: is inaccessible to disadvantaged Australians, including the elderly, and others with complex chronic disease; an inequitable system favouring the wealthy at the expense of ordinary Australians; and provides poorer health outcomes for many people.

B. THE IMPACT OF CO-PAYMENTS ON

i) Consumer's ability to access health care,

Intrinsic to any discussion on ability to access health care is equity, or the Australian ideal of the 'fair go'. We pride ourselves on being an equitable, egalitarian people, with the 'fair go' at the core of our collective psyche. The underpinning philosophy of universality borne by Medicare allows all Australians access to quality health care, regardless of their financial, social or health status.

As a nation, we are poised on the edge of changes to our universal health system that will ensure access is no longer universal and will increase the cost burden on those who can least afford it. Proposed savings from a co-payment are a false economy. Any small initial savings will be overtaken by significant increases to the budget due to increased hospital presentations and admissions[5] [6]. Evidence of the obstacles presented by co-payments already exists, with low income earners and those suffering chronic conditions being most disadvantaged[7].

A flat co-payment (regardless of the amount) imposed on GP services will disadvantage poorer Australians. Co-payments, whether for GP visits, hospital visits or pharmaceuticals, will ensure that those who can least afford to neglect their medical care will in fact neglect it. The less money people have, the more they pay in relation to their income and liabilities. So as costs for health care increase, many people will be forced to ignore aspects of their care.

GP visits are of critical importance for early diagnosis and preventative health management. While a small co-payment may be regarded as a modest increase, evidence clearly demonstrates that co-

[5] Di Natale, R Lets improve, not discourage, access to primary care in *Health Voices Journal of the Consumers Health Forum of Australia* Issue 14 April 2014

[6] Trivedi, A.N.; Moloo, H; Mor, V. *Increased ambulatory care copayments and hospitalizations among the elderly* New England Journal of Medicine 2012;362 pp. 320 328

[7] Doggett, J. *Empty Pockets: Why Co-payments are not the solution*. Report to the Consumers Health Forum of Australia, March 2014

payments deter people from GP visits and may indeed strip healthcare of its early diagnosis and preventative healthcare capabilities[8].

Currently, Australians in rural and remote areas face access issues that are not only related to out-of-pocket expenses. Housing stress, distance to services, including GP services, expenses such as fuel costs, fresh food and groceries costs, all contribute to a family's ability to afford health care.

The rate of potentially avoidable hospital admissions and average length of stay increases with remoteness. The National Rural Health Alliance in 2011 estimated people outside major cities had approximately 190,000 more overnight hospital stays than people in major cities[9]. As they reported in 2011, 17.1% of people living in outer regional, remote and very remote areas presented at emergency departments compared to 12.3% of people living in major cities[10]. Increasing the burden on citizens in rural and remote areas may assist in alleviating Federal budgetary pressures, but will not improve access to quality health services.

ii) **Health outcomes and costs**

The views of the ANMF are clearly shared by other peak professional bodies. The Rural Doctors Association of Australia states that a mandatory co-payment for visiting a country GPs will prevent people seeing their doctor when they need to, leading to increased hospitalisation when those same people become acutely ill[11]. Further, the Centre for Remote Health considers the intention that a co-payment will save money for the health system "is a furphy"[12].

> "*The opportunity for early detection of serious illness may be lost if a person delays or avoids a GP visit because of the copayment*"[13]

The Australian Medical Association (AMA) also argues the implementation of co-payments for GP visits will increase costs to the health system and increase the red-tape for people and for GPs,[14] while Professor John Deeble says

> *"the projected savings are too small to warrant the problems it would cause*[15].

Health insurance adds significant cost to the health system[16] through Medicare subsidies of private patients in private hospitals, utilising Medicare funded diagnostic and pathology services and allied health services. In 2012-13, Medicare contributed $8.2billion to GPs and specialists, $1.7billion to out-of-hospital allied health, psychological counselling and dental care. An additional and staggering $8.7

[8] Del Mar, C. B. *Editorial. Copayments for general practice visits*. MJA 200(7) April 2014
[9] National Rural Health *Alliance Australia's health system needs rebalancing: a report on the shortage of primary care services in rural and remote areas* NRHA (2011) http://ruralhealth.org.au/document/australias-health-system-needs-re-balancing-report-shortage-primary-care-services-rural-and
[10] National Rural Health Alliance *Submission to the Senate Standing Committee Community Affairs Reference Committee Inquiry into the out-of-pocket costs of Australian healthcare*. NRHA May 2014
[11] Dr Ian Kamerman, President of the Rural Doctors Association of Australia. *Bush Telegraph*, ABC Radio National, 24/4/2014.
[12] John Wakerman, Director of the Centre for Remote Health, Northern Territory. *ibid*
[13] Del Mar, C. B. *Editorial. Copayments for general practice visits*. MJA 200(7) April 2014
[14] Hambleton, S. *AMA Slams Commission of Audit Report*. 6Minutes of interesting stuff for doctors today. 2 May 2014
[15] TQN April 2014 p.26
[16] Cheng, T.

billion of Medicare funds paid for private pathology and diagnostic tests (including some out of hospital tests) and treatment of private patients in public hospitals[17].

As evidence suggests, health outcomes will worsen as people delay GP visits and filling their prescriptions. The consequences of delaying treatment and maintaining wellness will then be borne by those working in the community, primarily by nurses and welfare workers, and by the acute hospital sector. The acute sector will be further stressed by people presenting in emergency departments in an attempt to avoid cost, and seeking clinical interventions which are left until later, sometimes too late.

C. THE EFFECTS OF CO-PAYMENTS ON OTHER PARTS OF THE HEALTH SYSTEM

According to an international report, 25 per cent of Australians paid more than $1,000 annually in out-of-pocket medical expenses, which was the second highest of 11 comparable countries. This includes services such as specialist care, dental care, diagnostic tests and pathology[18].

From a policy viewpoint there are many chances to practice health promotion and preventative primary healthcare, and opportunities to address lifestyle factors, chronic conditions and to detect cancer in its early stages. The savings estimate of the proposed co-payment is approximately $750 million over four years. The ANMF believes this perspective is short-sighted and that a disincentive to visit GPs will have larger impacts on the health system as a whole and will significantly increase costs for future generations. Opportunities for reaching the poorest and sickest, the marginalised and vulnerable people in our community will be significantly impacted by any co-payment. Examples of those at high risk include:

- Aboriginal and Torres Strait Islander people who already experience lower access and use of health services, for example only 36% of Aboriginal and Torres Strait Islander women were screened for breast cancer, compared with 55% of non-Indigenous women.
- Older people make up over 40% of GP visits. According to the 2008 South Australian Health Omnibus Survey, those aged 65 plus had much lower levels of adequate health literacy than younger people ('only 22% of South Australians aged over 65 had adequate functional health literacy compared with 69% of those aged 25–44'[19].
- People with preventable chronic conditions comprise 35% of the population. Health promotion, lifestyle counselling, proactive care and preventative management will both save costs and improve health outcomes.
- Those with poor oral health care. A specific recommendation of the National Health and Hospitals Reform Commission was to improve health through health promotion and improved access to dental care[20]. The report identifies a gradient by socioeconomic status (oral health improves incrementally from the lowest to highest income groups); this suggests the impacts of introducing disincentives to Medicare funded services would include avoiding GPs and further impair the individual's ability to afford already expensive, out-of-pocket cost-dependent dental care.

[17] Sivey, P. *Want Medicare savings? Stop paying for private hospitals*. The Conversation, 18 March 2014
[18] ABC News. Fact Check. 7 May 2014. Available at http://www.abc.net.au/news/2014-05-07/catherine-king-gp-co-payment-claim-overreach/5421798
[19] Australian Institute of Health and Welfare. *Australia's Health 2012.* Canberra: AIHW, p 184
[20] National Health and Hospitals Reform Commission. A Healthier Future For All Australians: Final Report. Canberra: Commonwealth of Australia, 2009, p 153

There is a dramatically increasing prevalence of Type II Diabetes in Australia[21] Despite this fact, Australia is one of the best performing countries in the OECD for preventing acute hospital admissions for complications arising from diabetes[22]. Australia also has one of the highest obesity rates in OECD (one in four Australian adults and one in 12 children are overweight or obese)[23]. Smoking, high blood pressure and now obesity are major contributors to the burden of chronic disease.

D. THE IMPLICATIONS FOR THE ONGOING SUSTAINABILITY OF THE HEALTH SYSTEM

Sustainability of the public health system requires attention, political will and commitment as much as it requires adequate funding. The current Government is promulgating a view that the health system is in a state of crisis and that things must change. Duckett[24] has named this philosophy *sustainability panic*, a means of justifying a contraction of publicly funded healthcare, available only to the most vulnerable.

To ensure sustainability of the health system, appropriate and responsible allocation of resources is required. A much greater emphasis must be placed on prevention and primary health care, including primary care. This will need to include much more effective use of Nurse Practitioners and improved access to GPs, with a broad focus on health promotion, prevention and chronic disease management for individuals and communities.

Australians have traditionally paid a high price for pharmaceuticals. While the Pharmaceutical Benefits Scheme (PBS) heavily subsidises common medicines and those provided to concession card holders, it is now generally accepted that replacing brand name medicines with less expensive generic medicines is cost-effective. However, more research and policy work must be done by this Government on how decisions are made on which pharmaceuticals are subsidised and which are not. Simply replacing older, out of patent medicines with newer, more expensive medicines will increase, not decrease out-of-pocket costs to the public[25].

Dental care is a significant area of expense for Australians, and exemplifies the fact that people will not avail themselves of services if out-of-pocket expense is unaffordable[26].

There are revenue streams available to the Government within existing tax structures which should be accessed to increase the overall pool of resources and to avoid any increase in out of pocket health costs for consumers[27]. To shift the burden of health care costs to individuals and particularly disadvantaged individuals when there are readily available and much more viable solutions, is simply unethical and is not supported by the ANMF.

[21] opcit AIHW pp 298, 305.
[22] Work of the Australian Government on diabetes. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-diabetes-gov
[23] opcit. AIHW, p 213-214
[24] Duckett, S. *How sensible health policy could end sustainability panic*. The Conversation, 8 April 2014
[25] Duckett, S et al. *Australia's bad drug deal: high pharmaceutical prices*. Melbourne: Grattan Institute, 2013
[26] National Oral Health Alliance. *Stop the rot: time to fill the gaps in oral health*. Joint statement from the National Oral Health Alliance, July 2010.
[27] The Australia Institute. Auditing the auditors: the peoples' commission of audit, 8 May 2014. Available at http://apo.org.au/research/auditing-auditors-peoples-commission-audit

F. THE ROLE OF PRIVATE HEALTH INSURANCE

The ANMF does not support increasing the role of private health insurance beyond funding private services and facilities for those who choose to access this sector of the health system. While acknowledging and respecting the need for an effective private health system, the ANMF does not support public subsidy of the private health system.

Forcing middle to higher income earners into private health insurance, by denying them access to Medicare, will not result in a cheaper health system. It is a simplistic strategy which will shift the numerical value from the Government's budget line. This cost-shifting is an expedient strategy which will bring little benefit, especially in cost management, to anyone except large health insurance companies.

As demonstrated by international experience, health costs will be driven up and outcomes will worsen. As Professor Stephen Leeder points out, "ever more expensive care does not mean ever better health care"[28].

Suggestions that health insurers be allowed into the primary care and primary health care sectors will place significant obstacles between ordinary people and accessible, affordable primary health care via General Practice. It will increase out-of-pocket expenses to the consumer, regardless of their capacity to pay, while health insurers profit.

Increasing the role of private health insurance could also result in alarming outcomes where doctors are restricted in their clinical decision making because of cost containment measures. As a consequence of co-payments, GPs may only offer treatment options to certain individuals based on what they can afford, rather than those preventions and treatments which are supported by evidence as best practice.

Increasing the role of private health insurance will further risk the potential for 'luxury' and other treatments delivered by workers who are not regulated health professionals, to be marketed as components of prevention and primary health care because of their potential for 'lifestyle improvement'.

It is widely accepted that healthy lifestyles and effective prevention can assist in forestalling the onset of illness and significantly reduce health care costs. This evidence is the basis of modern, effective primary health care. However, these aspects of the health system will only be effective when provided by a qualified, regulated health professional workforce and underpinned by a solid evidence base.

Market drivers

Australians agreed to pay for Medicare through the taxation system with the dividend on their investment being access to an equitable and quality healthcare system. Waiting times notwithstanding, outcomes remain better than most OECD countries, as stated earlier.

When focusing on the market drivers, consideration must be given to the electorate. A political mandate does not exist to irreparably undermine Medicare through allowing market forces to be the only driver for changes to the healthcare system. A lack of political will to maintain and improve universal access and equity, and to minimise out-of-pocket expenses, will meet with opposition and outrage from the electorate and from health professionals.

[28] Leeder, S. *Six steps to help preserve universal health care* in *Health Voices Journal of the Consumers Health Forum of Australia* Issue 14 April 2014. pp6-7

Other comments

Major improvements in clinical care are generated in the public sector. The most complex, difficult and urgent cases are dealt with in the public sector. The sickest Australians are cared for in the public sector. The most sophisticated surgery and post-surgical care occurs in the public sector. Breakthroughs in healthcare are developed, trialled and implemented in the public sector, the private sector being far more risk averse. The public sector is modern and responsive. Innovation, change and research into health and into disease are all led by the public sector. Teaching, research and innovation are all less developed in the private system. Staffing levels, skill-mix and access to a full range of health professionals are all superior in the public system.

Teaching emerging health professionals occurs on an enormous scale within public healthcare, benefiting thousands upon thousands of health professionals in every discipline every single day. Without this extensive teaching and learning, and without broad access to our best clinical staff, the healthcare system would be significantly stunted. It would take years for the private sector to develop its systems to match those of the public sector – and only then if it were willing to commit.

Conclusion

Access to affordable, equitable, quality healthcare is a fundamental right for every Australian. Medicare has been an efficient and effective mechanism to distribute resources ensuring timely and equitable access to affordable healthcare on the basis of clinical need rather than ability to pay. Better value for money can be achieved through enhanced utilisation of regulated, qualified registered nurses, midwives and Nurse Practitioners who have a huge role to play in primary health care, throughout the community. Nurses and midwives work across the nation in every area of health and aged care. From schools to oil rigs, from antenatal care to aged care, and in every location and health specialty between, nurses and midwives provide efficient, expert, evidence-based care and services.

Health promotion and prevention, lifestyle change and management of chronic conditions and other mechanisms for minimising admissions to hospitals will not be affordable for disadvantaged people if a co-payment is introduced. The increased cost burden will fall on those who can least afford it. Through greater numbers of admissions, greater burden will fall on public hospitals. People presenting to hospitals will be sicker and require expensive, complex intervention and care.

Medicare must not be undermined or dismantled. Medicare must not be used to provide private health services. Co-payments are not the answer to funding Medicare. The taxation system is the logical, equitable place to find funds.