



Submission to The Senate Select Committee on Health

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Introduction

The Australian Nursing and Midwifery Federation (ANMF) is the national union for nurses, midwives and assistants in nursing with branches in each state and territory of Australia. The ANMF is also the largest professional nursing organisation in Australia. The ANMF's core business is the industrial, professional and political representation of its members.

As members of the union, the ANMF now represents over 240,000 registered nurses, midwives and assistants in nursing nationally. They are employed in a wide range of enterprises in urban, rural and remote locations, in the public, private and aged care sectors including nursing homes, hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, and off-shore territories and industries.

We thank the Select Committee on Health for the opportunity to comment on the Abbott Government's budget cuts to health and the effect of these cuts on the Australian community. This submission broadly addresses the key terms of reference for the Committee, which are of most significance for ANMF members. The submission provides comment on the suitability of the Abbott Government's proposed budget measures for health and offers alternative policy solutions.

Background

The members of the Australian Nursing and Midwifery Federation are committed to the provision of health as a public good with shared benefits and shared responsibilities. We consider that access to adequate healthcare is the right of every Australian and a crucial element of the Australian social compact.

We are committed to publicly funded universal health insurance, i.e. Medicare, as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

We are also faithful to the principles and philosophy of primary health care: social justice, equity and self-determination, with a focus on early intervention to promote health and prevent illness.

While we recognise there are substantial reforms that can be made in order to improve the system, we believe that the principles on which Medicare was founded must be preserved: equity, efficiency, simplicity and universality.

Our members are deeply concerned by a number of measures in the Federal Budget related to the health portfolio. While much of the public response to these measures has been focused on the co-payments of more concern is that the Government is seeking to introduce wide ranging policy measures, which will change our health system irrevocably.

The series of mandatory co-payments and the Federal Government's abandoning of the agreed funding arrangements with the State and Territory governments under the National Health Partnership Agreement are critical to the Government's policy agenda.

Shifting costs through these measures onto individuals and to the states and territories is an unnecessary, short-sighted and lazy option by the Government. There are numerous solutions readily available to the Government which will not only improve equity but will also ensure sustainability of the health system into the future.

However, these solutions require fixing system fundamentals which takes political will, capacity and competence. Consequently, it appears, they are being avoided by the Government.

Nonetheless, the ANMF is committed to improving the health system and has outlined a series of policy solutions which should be implemented instead of the Government's 2014/15 health budget measures.

Policy Statement 1

Reject the Government's abandoning of the National Health Partnerships Agreement

The National Health Partnerships Agreement had a strong emphasis on improving efficiency and capacity while recognising the reality that growth in Federal Government funding is necessary to respond to growing public hospital costs.

The National Partnership Agreement on Improving Public Health Services, was designed to drive major improvements in public hospital service delivery and better health outcomes for Australians by facilitating improved access to public hospital services, including elective surgery and emergency department services, and subacute care.¹

Under this Agreement, the previous Federal Government committed to providing a financial contribution to the States and Territories to support the delivery of agreed initiatives. Despite indications that these initiatives were having some success², this commitment has been revoked by the Abbott Government and the funding withdrawn.

The move away from the Commonwealth sharing the cost of the growth of hospital admissions and other activity is anticipated to cost the States and Territories billions of dollars in health funding. As this measure took effect on 1 July 2014, these cuts have already commenced.

Our members have calculated what these cuts will mean to their state health systems. For example, South Australian nurses and midwives estimate they will see a reduction in funding of \$655 million from their health system over the next four years. While in Victoria cuts of \$982 million to 2018 will equate to over 185,000 surgical procedures cancelled; with a further cut of \$155 million in funding by removing an additional 332 sub-acute hospital beds across the state.

Consequently our members are deeply concerned about the impact these cuts will have on their capacity to provide safe, quality patient care. They advise that these cuts are not sustainable and will present unprecedented funding shortfalls for state and territory health systems.

Alternative policy option

- Restore the commitment to the Commonwealth contribution to cost of growth in public hospital funding as agreed by COAG

¹ COAG, The National Health Reform Agreement – National Partnership Agreement on Improving Public Services. Online: http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-workforce-reform/national_partnership.pdf

² AIHW 2013. Australian hospital statistics 2012-13: emergency department care. Health services series 52. Cat. no. HSE 142. Canberra: AIHW.

Policy Statement 2

Reject the Government's series of mandatory co-payments for GPs and pathology

There is a distinct lack of evidence in relation to benefits that may be gained from mandatory co-payments. There is however, evidence for the potential limitations of mandatory co-payments. They do not discriminate between serious and non-serious occasions of service; they are not efficient because they hinder prevention and early intervention; and they increase inequity because they deter already marginalised sections of the community from accessing care.

There is evidence to suggest that introducing these mandatory co-payments will result in people delaying or avoiding consultations, diagnostic tests and prescriptions due to costs. They will serve as a further disincentive to people already struggling to access care.

The Government's intention is to deter people from accessing unnecessary care but it is important to note that a GP co-payment won't make any distinctions. Most people attend GPs because they don't know if their symptoms are a sign of something more serious. For example, irritability and fever in a toddler may be associated with teething or it could be the early stages of a potentially catastrophic meningitis infection. It is the role of the clinician not the consumer to make this judgement.

Early intervention in diseases such as cancer, diabetes and those related to the cardiovascular system is critical in reducing mortality and morbidity and avoiding the need for more complex and expensive treatments down the line. Similarly, patient education delivered in the primary health care setting will contribute to the lifestyle changes that are critical in preventing the so called 'lifestyle diseases'. Imposing a co-payment to discourage early intervention in such situations is a profoundly regressive move that could result in serious harm and far greater expense in the longer term.

Not only is it illogical to implement a barrier to access to primary health care where prevention, early intervention and hospital avoidance activities currently occur extremely efficiently. It is simply unfair to reach for a 'quick fix' which will only serve to shift costs, not save costs.

The ANMF considers that *incentives* are far more successful in delivering benefits and improving outcomes than *disincentives*. We therefore reject the Government's proposal to implement mandatory co-payments for GP visits and out of hospital pathology and radiology.

Alternative policy options

A sensible solution is to increase incentives to encourage changes in both health provider behaviour and individual behaviour, this would include:

- Retaining bulk-billing while reviewing and improving Medicare arrangements (i.e. MBS review), including ensuring that MBS item fees are assessed against contemporary evidence of safety and effectiveness.
- Investigating better ways to fund and manage chronic conditions – the current system of fee-for-service provision of care for chronic disease management may not be the best model for the future. A more efficient model could be to reward results as is done in other countries, for example, United Kingdom (UK) and New Zealand.

Policy Statement 3

Reject the increased co-payment for pharmaceuticals

Australians pay too much for their medicines, by an astronomical amount, when compared to the prices paid in New Zealand, the UK and Canada. This already acts as a disincentive to people in filling their scripts and will be greatly exacerbated if the costs of pharmaceuticals are increased further.

This is exemplified by the COAG Reform Council's report released in June 2014 which identified that 8.5% of people in 2012-13 delayed, or did not have prescriptions filled due to cost. The report found that this is up to 12.14% in disadvantaged areas and a shocking 36.4% for Indigenous Australians.³

Medicines compliance is extremely important. For example, appropriate medicines following myocardial infarction substantially reduces morbidity and mortality and compliance with prescribed regimes is crucial in achieving the best possible health outcomes.

Research has demonstrated the clear benefits for those who comply with prescribed regimes; further morbidity is reduced without increases in net monetary costs⁴. But as demonstrated above costs are one of the key reasons that many people do not adhere to prescribed medicines regimes.

In short, investment in access to medicines avoids expensive complications later on. Indeed, it is estimated that the cost of hospital admissions associated with non-adherence to prescribed medicines is as high as 10% of overall hospital costs in the United States (US). The Government's proposal to increase the amount paid by individuals for medicines is likely to achieve even worse outcomes as it will exacerbate the issue of non-compliance due to cost.

The absurdity is that there are billions of savings that could be achieved by better pricing arrangements. The Grattan Institute explains that:

...the problem is how the Government sets prices. Vested interests are involved in price negotiations, there is no cap on expenditure, and the price cuts when a drug goes off patent are far smaller than in many other countries.⁵

There is no sound reason why Australians should be paying so much more than the rest of the world for medicines and even less justification for the Government to ask us to pay more.

Alternative policy options

- The Government must undertake a comprehensive review of the PBS pricing structures, including the release of international comparisons of Australia's medicines pricing.
- There should be benchmarking to establish fair market prices and an independent medicines pricing body established to ensure reasonable prices are maintained.

³ COAG Reform Council. National Partnership Agreement on improving public hospital services: performance report for 2013. Sydney: COAG Reform Council, 2014. Online: <http://www.coagreformcouncil.gov.au/sites/default/files/files/Report%20for%20National%20Partnership%20Agreement%20on%20Improving%20Public%20Hospital%20Services%202013.pdf>

⁴ Brown, M.T. & Bussell, J.K., Medication adherence: WHO Cares?, *Mayo Clin Proc.* 2011 April; 86(4): 304–314.

⁵ Duckett, S., Breadon, P., Ginnivan, L., and Nolan, J. 2013, Poor Pricing Progress: Price disclosure isn't the answer to high drug prices, Grattan Institute

Policy Statement 4

Contain the role of private health insurance and the private health sector

The Abbott Government's Federal Budget 2014/15 clearly indicates the Government's intention to increase the role of the private health sector and private health insurance companies.⁶

The ANMF has concerns with this direction from the Government as it has been widely demonstrated that private health insurance is an expensive way to fund health care. Lesley Russell, Senior research Fellow, Australian National University, who has extensively examined and compared the health systems of Australia and the United States (US), points out that private health insurance is a high-cost mechanism for achieving what taxes and national insurers, such as Medicare, do much more efficiently.⁷

Ms Russell's research further demonstrates that in the US:

*Multiple players in a supposedly competitive marketplace have conspicuously failed to deliver affordable access to services, an appropriate price for these services and superior quality. Significant redundancies and inefficiencies arise from the complexity of health care administration and there is evidence of an inverse relationship between administrative complexity and quality of care.*⁸

As reported by the ANMF NSW Branch, the administrative costs of private health insurers including profit margin are about three times that of Medicare, with Australians paying \$2.5 billion per year towards private health insurers' administration fees and profits. In Australia only 84 cents in every dollar collected by private insurers is returned as benefits, the rest goes to administrative costs and corporate profits. By contrast Medicare returns 94 cents in the dollar.⁹

Private insurance does not contribute to efficient distribution of resources because competition among insurers renders them powerless to influence the prices demanded by providers. In contrast, a single national insurer like Medicare has the market power to put some discipline into prices and utilisation.

The ANMF considers that the private health sector has a legitimate and important role as an alternate choice for the provision of health care. However, its operation and any future expansion must not be at the expense of publicly provided services available to all.

The Government's clear intention is to expand the role of private health insurance such that it will be at the expense of the public health system. In particular, allowing private insurers into the primary care sector will place significant obstacles between ordinary people and accessible and affordable care and increase out-of-pocket cost. It will potentially influence the treatment decisions of GPs and other providers based on cost outcomes. It could leave large sections of the community without care as private insurers may be compelled to be selective in offering cover to those who will

⁶ Commonwealth of Australia 2014, Budget Statements – Health – Outcome 6, Private Health, [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/\\$File/2014-15_Health_PBS_2.06_Outcome_6.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/$File/2014-15_Health_PBS_2.06_Outcome_6.pdf)

⁷ Russell, L. 2014, Creating a better health system: lessons from the US, *The Conversation*.

⁸ Ibid.

⁹ New South Wales Nurses and Midwives Association, 2014, Submission to NSW Senators re Budget 2014/15. Online: <http://www.nswnma.asn.au/wp-content/uploads/2014/06/submission-to-NSW-Senators-re-budget.pdf>

reap them the greatest reward, for example, restrict access to cover for those with chronic conditions.

It appears that this could be a prelude to the introduction of 'managed care' arrangements. We reject the notion that an insurance organisation, effectively a financial institution, should intrude into clinical decision making processes. Restricting the consumer's choice of provider; the provider's ability to negotiate fees; and, the autonomy of the decision making process are anathema to how the Australian system has been structured thus far. This is not in the broader interest of quality and equity.

The ANMF does not believe increasing the role of private health insurance will preserve and protect public community and preventative health in state jurisdictions, which have been decimated in recent years. Our Queensland members report that in the last two years the state government has overseen and orchestrated the closure of many community health services, with either the termination of those services or their transfer to private providers.

The closure or significantly reduced capacity of these public services will be exacerbated by the expansion of user-pays insurance schemes. The lack of affordability of such schemes for the poor is precisely why public services were implemented in the first place. The consequences of such decisions will be felt for many years to come.

The public contribution to private health insurance (PHI) is already too great and does not provide reasonable return for the wider community. This currently occurs through a number of mechanisms but one which could be changed to return significant savings to the Government is the PHI rebate. This was initially introduced to encourage greater uptake of PHI by Australians, however the proportion of those with PHI has remained consistent for the last decade and has not taken the pressure off public hospitals.¹⁰ In the meantime billions of dollars of taxpayers' money are being withheld from the public health system for the benefit of PHI companies. This must be addressed.

The most effective way to reduce demand for public hospital services is better prevention and primary care.¹¹

Alternative policy options

- There should be no imposition of penalties for those who do not take out private health insurance regardless of their income. Medicare is not a safety net, it is a universal health insurance scheme, which is for everybody.
- The public subsidy of private health insurance should be removed with the savings directed to the public health system. This could be done gradually – a 10% reduction in the rebate would return significant savings to the Government even accounting for potential increase in activity to be accommodated by public hospitals.¹²
- Ensure that private health insurance companies are restricted from operating in primary care. Allowing private health insurance companies into this domain will increase inequity and reduce efficiency.

¹⁰ Australian Bureau of Statistics, Year Book Australia, 2012, Health care delivery and financing. Online: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Health%20care%20delivery%20and%20financing~235>

¹¹ Dwyer, J. 2014, The structural reform of Medicare rather than its funding is the real challenge, Pearls and Irritations. Online: <http://johnmenadue.com/blog/?p=2252>

¹² Cheng, T.C. 2014, Does Reducing Rebates for Private Health Insurance Generate Cost Savings?, Melbourne Institute Policy Brief No. 3/13, Online: http://www.melbourneinstitute.com/downloads/policy_briefs_series/pb2013n03.pdf

Policy Statement 5

Increase focus on prevention and primary health care

Overall, Australia's health system performs very well. However, unacceptable deficiencies continue to exist. The gap between overall health outcomes and indigenous health outcomes continues to be a disgrace, while people in rural areas and lower socio-economic groups live shorter lives and experience more illness than those living in major cities and with higher incomes.

These groups have poorer access to primary care, mental health care, maternity services, dental care, allied health and specialist services and are more likely to experience problems related to obesity, alcohol use and smoking.

This is particularly concerning in the context of the Government's policy intentions for preventive health care. The recent abolition of the Australian National Health Prevention Agency (ANHPA) and Medicare Locals, is a shocking example of the Government's disregard for prevention and primary care. This has served to withdraw resources from and reduce focus on prevention and primary care. In particular, this retrograde move will negate the gains made by ANPHA in relation to reducing obesity and alcohol and tobacco use.

These gaps and deficiencies could, and should, be addressed through improved preventive health care. This should be our top priority if we are to improve our overall health particularly for those who lag behind.

Not only is prevention better than cure it makes the most economic sense. This is now being recognised world-wide. As the Abbott Government takes the step to reduce focus on prevention, the rest of the world, including the United States under Obamacare, is increasingly investing in preventive health care and recognising that this must involve a whole of government approach.¹³

With an increasing chronic disease burden, an ageing population, and many people in poorer health often from avoidable conditions, who are generally less productive, it makes much more sense to invest where we can reap the most benefit.

Currently, hospital costs account for around 40% of health expenditure in Australia. Comparatively hardly any spending, less than 2%, is on preventive health and primary care; the focus on the hospital system currently consumes health spending at the expense of primary care.

The way to contain costs is through investment in prevention and early treatment through primary care services and effective primary health care, rather than hospitals. The Productivity Commission reported that about 750,000 hospital admissions could be avoided if we had effective intervention in the weeks leading up to hospitalisations¹⁴. Remodelled primary care is critical.

¹³ Russell, L. 2014, Creating a better health system: lessons from the US, *The Conversation*.

¹⁴ Productivity Commission, 2104, Report on Government Services 2014 – Health, Online: <http://www.pc.gov.au/gsp/rogs/health>

Alternative policy options

- Establish primary care systems that encourage people to enrol in wellness maintenance programs as is now occurring widely throughout the world. This approach encourages people to take responsibility for their own health with assistance from a range of health professionals without using a 'stick' or other punitive measures.
- Ensure that primary health networks (in whatever form) focus on disease prevention, health promotion, equity and social determinants of health.
- Ensure that private health insurance companies are restricted from operating in primary care. Allowing private health insurance companies into this domain will increase inequity and reduce efficiency.

Policy Statement 6

Improved workforce utilisation

Australia has a highly qualified and skilled health workforce which is currently dramatically under-utilised. Nurses and midwives, allied health professionals and paramedics are denied opportunities to realise their full potential. Opening these opportunities and undertaking appropriate workforce reform, which should occur primarily in the primary care sector and in transition care, will allow us to provide better service to people much more cost effectively.

Nurse practitioners (NPs) are a perfect example of how better workforce utilisation could lead to reduced costs while improving care. For example, NPs already play a valuable role in aged care as a complement to medical practitioners' practice. In residential aged care, NPs on site can provide assessment and treatment in a timely manner avoiding lengthy wait times for the medical practitioner or transferring the resident to the emergency department (ED). NPs can also provide clinical leadership and education to nursing staff thereby contributing to improved care overall.

A review of seven studies demonstrated that NPs can reduce hospitalisation and ED transfers of aged care residents and recommended the introduction of NPs across residential aged care facilities as primary care providers.¹⁵

Further research has indicated that there are also benefits to be gained by allowing registered nurses to work to their full scope of practice and increasing the scope of practice of physiotherapists in emergency departments, both in reducing costs and improving outcomes.¹⁶

These options must continue to be explored and implemented, which will necessarily require Government funding and support. However, the Government has given no indication that better workforce utilisation is part of their wider policy agenda for health.

¹⁵ JBI Effectiveness of Nurse Practitioners in residential aged care facilities Best Practice 14(19) 2010, Online: <http://connect.jbiconnectplus.org/ViewSourceFile.aspx?0=5385>

¹⁶ Health Workforce Australia [2014]: Expanded Scope of Practice and Aged Care Workforce Reform Progress Report, Online: <http://www.hwa.gov.au/sites/default/files/Expanded-Scope-of-Practice-and-Aged-Care-Workforce-Reform-Progress-Report20140321.pdf>

Alternative policy options

- Allow nurses and midwives to work to their full scope of practice.
- Significantly increase the numbers of nurse practitioners and eligible midwives and ensure that there are positions made available for them.
- Expanded roles for other health professionals as appropriate, e.g. occupational therapists and pharmacists who should be better integrated with primary care and other health professionals.
- The MBS needs to be reviewed and transformed to remunerate a wider range of health professionals, at appropriate levels.

Policy Statement 7

Investigate alternative revenue sources

Sustainability of the health system requires attention, political will and commitment as much as it requires adequate funding. The ANMF has been very critical of the Government's proposition that the health system is in crisis and the budget is in a state of 'emergency'. We regard this attitude as unnecessary and inaccurate rhetoric.

We have also been extremely critical of the Government's proposed solutions which are namely to shift the burden of health care costs to individuals and particularly disadvantaged individuals when much more viable solutions are readily available. Indeed we regard this approach as unfair and unethical.

In addition to the alternative policy options we have outlined above, there must be an increase in government capacity to fund important services for the community through restructured taxation and fairer distribution of resources. There are revenue streams available to the Government within existing tax structures which could be accessed to increase the overall pool of resources available to governments. There are also new revenue streams, widely used in the northern hemisphere, which could be accessed to increase revenue.

Alternative policy options

- Reform of tax concessions - limiting access to growing tax concessions such as superannuation, which bring most benefit to those with high incomes, could provide additional funding for essential public services.
- Review the amount of tax paid by high income earners. The Australia Institute reports that the cumulative cost of tax cuts since 2005 is about \$170 billion with the top 10% of income earners receiving more of that \$170 billion than the bottom 80% combined. Both tax brackets and tax rates for the highest income earners need to be reviewed.
- Introduce a *Robin Hood* tax – The ANMF believes that instead of disadvantaging ordinary people through tight budget measures, it is time the Government took and redistributed a

larger share from those involved in the billions of dollars in financial transactions. The 'Robin Hood' tax, also known as a financial transactions tax, is a 0.05% tax on institutional trades of currencies, stocks, bonds, derivatives and interest rate securities. It is widely implemented across the European Union. If governments can tax ordinary Australians on basic requirements such as housing, then they certainly can and should tax international financial transactions.
