New South Wales Nurses & Midwives' Association

Submission to NSW Senators
Re Budget 2014/15

NSW Nurses and Midwives' Association &
Australian Nursing and Midwifery Federation – NSW Branch
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The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes assistants in nursing (who are unregulated), enrolled nurses and registered nurses and midwives at all levels including management and education.

The NSWNMA has approximately 58,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions. Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also dedicated to improving standards of patient care and the quality of health services and aged care services.

NSWNMA is committed to the notion of health as a public good with shared benefits and shared responsibilities. We believe 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 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.

We are deeply concerned by a number of measures in the Federal Budget related to the health portfolio, principally the issue of increasing co-payments and the news that the Federal Government is walking away from the agreed

funding arrangements with the State and Territory governments under the National Health Partnership Agreement.

This 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, cuts which will commence almost immediately. This move creates deep uncertainty for the people of NSW in regard to our already stretched hospital services.

We believe that the commitments negotiated under the previous government were appropriate. The National Partnerships Agreement had a strong emphasis on efficiency whilst recognising the reality that growth in Federal Government funding is necessary to respond to growing public hospital costs.

It is vital that States have certainty with regard to public hospital funding. We have no doubt that this move by the Federal Government will be used by the NSW Government to justify further privatisation of health services in NSW. Privatisation will lead to less efficiency and less equity of access for the people of NSW. The evidence also shows that privatisation is not associated with improved quality and safety. We call upon the Senate to reject this budget initiative.

The evidence is also clear in relation to co-payments for access to primary health care: 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 only already marginalised sections of the community from accessing care.

We reject the Government's proposal to implement a $7 co-payment for GP visits and out of hospital pathology and radiology. It is a false economy to implement this barrier to access to primary health care. General practice is where prevention, early intervention and hospital avoidance occurs. It flies in the face of logic for a Government seeking to contain health costs to create new barriers to access for this most cost effective area of healthcare.

The data shows the out-of-pocket expenses in Australia are already high, too high for some, and this is creating an unacceptable barrier to effective healthcare for some people. The evidence indicates that in 2013, 16% of Australian adults reported that they had experienced cost-related access problems (did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care) and Australians' out-of-pocket

expenses were second only to the United States.[1] Imposition of a compulsory co-payment on general practice visits will exacerbate these concerns.

We know already that Australians most in need of health care are the ones least able to afford it[2] and the evidence shows that co-payments impact disproportionately on vulnerable groups:

> *The empirical evidence likewise indicates that vulnerable groups, including individuals with low income and in particular need of care, reduce their use relatively more than the remaining population in consequence of co-payment.*[3]

Delaying or avoiding consultations, diagnostic tests and prescriptions can have catastrophic consequences both for outcomes and costs of care. Australia is facing a major chronic disease burden in the future and it will become increasingly important to find more efficient ways of managing chronic illnesses. This will require more emphasis on primary health care and better integration of healthcare. It will be increasingly important that people with chronic diseases avoid expensive hospitalisations through easy access to early intervention, prevention and education about self-management in the most cost-effective settings.

Elimination of bulkbilling, imposition of a co-payment on general practice visits and creating barriers to access is exactly the opposite of what is required to respond effectively and efficiently to this future challenge. Hospital costs account for around 40% of health expenditure in Australia. The way to contain growth in this sector is through investment in prevention and early intervention in primary care services. This is a fundamental principal of healthcare.

In terms of the idea that a co-payment will discourage only unnecessary contact with health professionals, this of course is nonsense. Most people attend GPs precisely because they don't know if their symptoms are a sign of something more serious. Irritability and fever in a toddler may be associated with teething or it could be the early stages of a potentially catastrophic meningitis infection. Early intervention in diseases such as cancer, diabetes and those related to the cardiovascular system is critical in avoiding the need for more complex and

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[1] Schoen, C., Osborn, R., Spires, D., Doty, M. Access, Affordability and Insurance Complexity are Often Worse in the United States Compared to 10 Other Countries, *Health Affairs,* December 2013 32:122205-2215, November 2013.

[2] AIHW 2012. *Australia's health 2012*. Australia's health no. 13. Cat. no. AUS 156. Canberra: AIHW.

[3] Kiil, A., Houlberg, K. How does co-payment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011. *European Journal of Health Economics,* August 2013.

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.

With regard to the increase in co-payments for medicines, consider the issue of medication compliance following myocardial infarction recently studied by Choudhry, et al, 2011.[4] Medication following myocardial infarction has substantially reduced morbidity and mortality and compliance with prescribed regimes is crucial. Costs are one of the key reasons that many patients do not adhere to prescribed drug regimes. The study examined almost 6,000 patients who had had one infarction, the impact of co-payments on compliance, outcomes and costs. It was clear that the group who had their co-payments waived were more compliant with prescribed regimes, they were less likely to experience further cardiovascular events, and most importantly, none of these benefits came at a net monetary cost. That is, the investment in access to medications avoided expensive complications down the line. Indeed, the New England Healthcare Institute estimates that the cost of hospital admissions associated with non-adherence to prescribed medications in the United States is as high as 10% of overall hospital costs.[5]

In terms of the role of private health insurance, local and global evidence shows that the more private health insurance is used to fund healthcare, the more expensive that system becomes, without any improvement in the quality of care. The administrative costs of private health insurers including profit margin are about three times that of Medicare. Australians pay $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. Private insurance does not contribute to efficient distribution of resources because competition among insurers renders them powerless to influence the prices demanded by

4 Choudhry, N, et al., Full Coverage for Preventative Medicines after Myocardial Infarction, *New England Journal of Medicine* 2011; 365:2088-2097.

5 New England Health Institute, Thinking Outside the Pillbox: Improving Medication Adherence and Reducing Readmissions, A NEHI Issue Brief, Oct 2012, http://www.nacds.org/pdfs/pr/2012/nehi-readmissions.pdf.

providers. In contrast, a single national insurer like Medicare has the market power to put some discipline into prices and utilisation.

NSWNMA rejects the notion that Medicare is unsustainable. The reality is that in the coming decades, spending on healthcare will grow but so will incomes. As we get richer we will be willing to spend more on maintaining our health.

This increased spending can be done as individuals in a user-pays system, or it can be done as a community in the form of a system of universal insurance such as Medicare. Either way, healthcare spending will grow and someone will be paying for it.

The difference is, in a highly privatised, user-pays system there will be winners and there will be losers. This is what happens in the United States. Excellent care is available to those who can pay for it (or insure against it) but many who fall ill cannot afford care and they and their families suffer terribly as a result. The highly privatised US healthcare system costs far more and delivers far less than systems based on universal insurance.

The rest of the developed world economies have chosen to rely on universal insurance because it is costs less, it is more civilised and equitable and results in better outcomes. Beneficiaries pay according to their means through progressive taxation and have access to the system on the basis of need.

No one is pretending that there are no changes that could be made to a 30 year old system like Medicare to make it more efficient – there certainly are many. But the notion that dismantling universalism, privatisation and shifting costs to individuals is the answer to making the system more sustainable is a recipe for higher costs overall and rising social inequity.

Serious commitments must be made to ensure that the rate of inflation of costs in health is contained in the future. It is vital that the Australian Government maintains the lever of universal insurance to maintain a downward pressure on costs. The shift towards greater user pays, greater privatisation and co-payments as a barrier to primary health care is profoundly inconsistent with the goals of efficacy and equity and must be rejected.