Submission to Senate Select Committee on Health

Victorian Medicare Action Group
October 2014

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http://vicmedicareactiongroup.weebly.com/

Victorian Medicare Action Group (VMAG) Submission to Senate Select Committee on Health, October 2014

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Introduction

The Victorian Medicare Action Group (VMAG) welcomes the opportunity to address the Inquiry. VMAG is an informal and to date self-funded alliance of interested people and organisations initially established more than a decade ago. We have a website and our membership is diverse. VMAG includes health practitioners such as nurses and doctors, health and community organisations, policy advocates, religious organisations, unions and consumers.

A particular current concern is about the impact of the proposed GP co-payment on access to health care which we addressed in our submission to the Senate Community Affairs References Committee's Inquiry into Out-of-pocket costs in Australian healthcare (and which we understand has been provided to this Inquiry).[1]

We have also recently written to all Victorian MPs because we are concerned about the impact of the federal government's moves to shift the burden of funding hospitals to the states. Along with the proposal to introduce co-payments for GP visits, these measures will leave hospitals cashed strapped to the extent that there will be significant pressure to impose co-payments in hospital emergency departments as well. We are asking all Victorian MPs what they think should be done about this and will compile the responses we receive in a report to be published on our website by early November 2014.

A high quality, equitable health system

VMAG is a strong defender of Medicare as our members are committed to a high quality, equitable health system for all. We see a key principle of Medicare is universal access free at the point of service and are particularly concerned about the impact that formally undermining this principle will have. We are especially concerned that despite the success of Medicare, people on low incomes and indigenous people in particular,

[1] VMAG (2014) Submission to Senate Community Affairs References Committee's Inquiry into Out-of-pocket costs in Australian healthcare http://vicmedicareactiongroup.weebly.com/submissions.html

have far worse health outcomes than other Australians and the data available suggests that they are far more likely to delay health care because of co-payments than other groups.[2]

Rather than creation of a two tiered health system where those who have the financial resources are able to access treatment and those without miss out, VMAG considers better paths to reform of the health system would include reinforcing public understanding that Medicare is NOT free. All taxpayers already contribute so that Medicare provides health insurance for all Australians. It does this through progressive taxation as well as the progressive impact of the Medicare levy.

A two tier health system is not cheaper

Medicare is cheaper and more equitable than a two tier system as a reflection on the US experience shows:

"…since Obamacare kicked in, emergency room admissions of non-payees are on the decline. During 2014, hospitals saw fewer uninsured patients, saving our health care system, thus far, an estimated $5.7 billion in uncompensated care, according to a Department of Health and Human Services report published late last month." [3]

This quote suggests that prior to the introduction of the Affordable Care Act, Americans unable to afford primary care were both going without timely care because of costs, and were ending up an impost on the hospital sector. The article goes on to suggest that the overall impact of the introduction of a more equitable system of health insurance covering a much greater share of the population than ever before is set to reduce the federal deficit by $150billion in overall savings.

[2] For example see para 3.54 Senate Inquiry into Co-payments suggesting 12% of indigenous people are likely to significantly delay health care because of cost issues. –

[3] Donna Brazile (2014) At last victory for middle America Daily Journal on Line October 4 http://dailyjournalonline.com/news/opinion/national-columnist/donna-brazile/at-last-victory-for-middle-america/article_b0dad3a1-1aed-5c15-966b-68e813bddc75.html

Inequity

VMAG is concerned that the impact of health costs already falls unevenly and inequitably in the Australian community. As noted we know that there is greater impact on people with chronic illnesses, indigenous and other groups whose health status is already poor.

But just some of the broader impact is illustrated by a few comments VMAG has gathered that people have made about out of pocket costs have made:

Eg women who are major users of the health system both as carers and as a result of their sexual and reproductive health needs

I get my pill prescription filled at regular intervals at my bulk bill clinic ... Why? ... Well why should I pay $60 for a signature on a piece of paper to then have to pay another $13 to fill that prescription?

Similar comments could be made about the need for common medications such as used long term by very many women post menopause.

People living outside metropolitan areas who have to factor in the costs of the additional time and expense of travel due to the maldistribution of health care

I live in a small rural community (Pop.9500). Doctors don't bulk bill here & this is true for most rural areas. It costs me minimum of $70 for a visit to the doctor, more if the appointment is longer than 10 minutes.

I would have to drive for at least two hours to find a clinic that will bulk bill me. It's not worth the $36 I'd otherwise save. That's all part of the price of not living in a capital city.

An example in terms of older people comes from pharmacy bills for a VMAG member's elderly father, a self-funded retiree. Averaging around $200 per month his expenses are illustrative of the costs faced when a person has multiple conditions – a common experience for the elderly.

So for all these reasons VMAG welcomes a conversation on the costs of our health care system. We also think it is important to consider the whole picture and not matters like co-payments in isolation.

Better ways to reform the system

Other ways to reform our health system costs associated with provision of universal health care can also assist rather than punish the already vulnerable. Certainly if increased funding is required for the health system VMAG would argue that there have been many reports and surveys showing for example Australians would be prepared to pay higher taxes in order to ensure access to health services. Funding the system via higher taxes, paid by those who can afford them, is a more equitable and sustainable way to address health care costs.

We note these costs are by no means out of control in terms of the percentage GDP Australia spends in this area (9.1% 2009-2013, if anything "much less" than many other developed nations).[4] Further significantly less of the health spend is from the public purse than in many other developed nations.[5]

There are supply side issues in terms of General Practice such as mal-distribution of GPs[6] that need to be addressed. This is particularly important for people in rural areas whose health is already statistically likely to be poorer and whose access to formal health care of any sort is also generally poorer than that available to their city counterparts. Reflecting this at least 8.3% of all Australian hospital admissions are considered to be preventable with the incidence rising the more remote the address of the patient.[7]

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[4] See OECD (2014) Health Statistics 2014 How does Australia compare? http://www.oecd.org/els/health-systems/Briefing-Note-AUSTRALIA-2014.pdf; World Bank Data on Health expenditure, total (% of GDP) http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

[5] OECD (2014) Health Statistics 2014 How does Australia compare? http://www.oecd.org/els/health-systems/Briefing-Note-AUSTRALIA-2014.pdf

[6] Australian Institute of Health & Welfare (AIHW) (2014) Major cities have greatest supply of medical practitioners, while remote areas have greatest supply of nurses and midwives, Media Release, September 9 http://www.aihw.gov.au/media-release-detail/?id=60129548768

[7] As at 2012-2013, Australian Institute of Health & Welfare (AIHW) (2014) Australia's hospitals at a glance http://www.aihw.gov.au/haag12-13/admitted-patient-care/

Some initiatives worth considering before punitive measures against consumers or starving our hospitals of funds is adopted could include much greater use of practice nurses, and nurse practitioners and expanding initiatives such as enhanced paramedic practice and aboriginal health workers. These are measures which the Australian Health Workforce Agency was exploring but it has now been abolished.[8]

Much greater support for and wider development of community health centres and services would also improve access to ambulatory care and allied health services that can deliver very effective preventive as well as the kind of health promotion and maintenance care that helps people stay well and out of hospital even with chronic health conditions.

We also believe there are more gains to be made by addressing efficiency for example improving the ability of the primary care sector including supporting GPs to undertake the broad array of services for which they are trained. There is a tendency to say that people attend hospital emergency departments for things that GPs are trained to do. Unfortunately this doesn't mean you can necessarily readily find one who has the infrastructure to do them – setting broken bones or doing sutures are just two examples.

Communication in the health sector of simple things like blood test results, x-rays and discharge summaries between the primary care sector and hospitals for example remains haphazard. This may be one of the reasons Australians go to hospital at a higher rate than almost any other developed country. It certainly doesn't promote improved management of chronic conditions. We need to ask why this is and why we have such a hospital centric system. Investing in a stronger primary care system backed

[8] See initiatives described on the Health Workforce Agency (HWA) website https://www.hwa.gov.au/our-work/current-programs and more generally HWA (2012) Health Workforce 2025 Doctors, Nurses and Midwives, Health Workforce 2025 - Doctors, Nurses and Midwives

up by strong preventive health programs would be a far more robust way of addressing rising health care costs and chronic health conditions.

A shift to Prevention: US Experience

VMAG supports a strong shift in emphasis to 'evidence informed' prevention and health promotion strategies to help both address rising costs, keep people out of hospital and enhance the health and productivity of the entire Australian community. The establishment of the Victorian Health Promotion Foundation attracted world-wide attention for this progressive step forward in its day. In VMAG's view it is very timely to reinforce Australia's commitment to preventive care. Unfortunately the new Australian National Health Prevention Agency has been abolished. We suggest that this also sends entirely the wrong message.

As indicated before, prior to the Affordable Care Act coming into effect, many Americans did not get the preventive care they need to stay healthy, avoid or delay the onset of disease, and reduce health care costs. As the US Department of Health and Human Services clearly states,

Often because of cost, Americans used preventive services at about half the recommended rate. [9]

These preventive services range from cholesterol tests to pap smears, and from HIV tests to mammograms.

The Affordable Care Act wasn't able to fix all of the ills of the lack of a coherent health system in the US. But in only its first year it has ensured a dramatic drop in the presentation of uninsured people at hospital emergency departments. And this is at

[9] US Department of Health and Human Services Affordable Care Act Rules on Expanding Access to Preventive Services for Women as at June 28, 2013
http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html

least in part not only because many more people are now insured but also because prevention is affordable and accessible for all Americans.

Specifically recognising the role that co-payments play deterring people from utilising many preventive health measures, the Affordable Care Act includes explicit provisions to address the problem. It requires most health plans in the US to cover recommended 'evidence-informed' preventive services without cost sharing. In 2011 and 2012, 71 million Americans with private health insurance gained access to preventive services with no cost sharing because of the law.[10] The range of preventive services required to be covered without cost-sharing include:

- screening for various cancers, diabetes, cholesterol, obesity, HIV and sexually transmitted infections, as well as depression;
- counseling for drug and tobacco use, healthy eating, and other common health concerns,.
- routine immunisation for children, adolescents, and adults
- a range of women's preventive services, including birth control, annual well-woman visits, testing for STIs and HIV, support for breast feeding, and screening and counseling for domestic violence.

This emphasis on prevention recognises that these services should be prioritised within the health system and encouraged with no impediments to their uptake. It recognises that the benefits like the costs are not only to the individual concerned but to their families and the broader community. [11]

[10] US Department of Health and Human Services, Ibid.
[11] See further Kaiser Family Foundation (2013) Obamacare and you: If you are a woman Oct 14 http://kff.org/health-reform/fact-sheet/obamacare-and-you-if-you-are-a-woman/
Focus on health reform: Preventive Services Covered by Private Health Plans under the Affordable Care Act September 2011 http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8219.pdf

Broader reform

Dental Care

Back in Australia, dental care is obviously a major issue. We note the findings of the COAG Reform Council that:

1. The costs of dental care remain an issue for many Australians, particularly Indigenous Australians.

2. Costs of dental professionals and of prescription medicines were a bigger problem in the most disadvantaged areas.[12]

The impact on general health of poor oral health can be profound. The impact of bad teeth on broader social determinants of health such as employability is probably equally profound. Dental care clearly should be a national responsibility.

Transport

Transport costs for rural people is a further major impediment to equitable access to health care that must be addressed creatively including as noted before greater use of nurses, paramedics and other allied health practitioners.

Infrastructure

Primary Care Partnerships (PCPs) were an innovation funded by the Victorian Government that attempted to drive better coordination and communication across the

[12] COAG Reform Council (2014) Healthcare in Australia 2012-13: Five years of performance, Chapter 3 http://www.coagreformcouncil.gov.au/sites/default/files/files/Chapter%20three_primary%20and%20community%20health.pdf

primary care sector. They also generally support collaborative initiatives to improve health care for their catchments.[13]

PCPs appear to have been a model for some Medicare Locals. VMAG notes that Medicare Locals are now being abolished and suggests that it is important their replacements reflect diverse governance including both a spectrum of health care professionals rather than GPs only. It is also important that the community is also represented by non-health practitioners in the governance structures. This reflects a democratic right to participate in key decision making structures in our community. It also reflects the importance of ensuring broad input and diverse perspectives in discussions about the issues that contribute to health and how to deal with them most effectively. [14]

Hospital funding

VMAG is concerned that in addition to the GP co-payments the federal government budget proposes to scrap the hospital funding model agreed to by the previous Government, and that the federal government pledge to meet 45 per cent of the growth in hospital costs initially and 50 per cent after 2017, will cease from July 2017.[15]

Linking the federal government's contribution to movements in the consumer price index (CPI) and population growth leaves the states and territories facing a shortfall in funding since health costs traditionally rise above the CPI. From 2014-15, the federal government will also cease the funding guarantees which promised that no state would

[13] Department of Health Victorian Government Health Information Primary Care Partnerships http://www.health.vic.gov.au/pcps/about/index.htm
[14] Department of Health & Ageing (2003) Healthy Participation, prepared by Health Issues Centre for the National Health Strategy
[15] Australian Parliamentary Library (2014) Budget Review 2014-15 Index prepared by Amanda Biggs http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201415/HealthFunding#_ftn1

be financially worse off as a result of transitioning to the activity based funding arrangements which apply from 2014-15.

The combined savings for the federal government from implementing these two measures are forecast to be at least $1.8 billion over four years. This is not a saving for Australians because the costs still have to be met. This is simply a massive cost shift to the states that they do not have the income to meet. VMAG is concerned the result will be the introduction of co-payments in emergency departments and other cuts wherever they can be made.

Co-payments

The introduction of a flat co-payment bears no relationship to people's capacity to pay. VMAG is concerned that the federal budget proposal for co-payments to visit the GP is being considered in isolation of all of the other out of pocket expenses people already pay for. Research has shown that existing consumer out of pocket expenses already comprise over 17% of total health care expenditure in Australia making consumers the largest non-government source of funding for health goods and services.[16]

Recent data collated by the Commonwealth Fund[17] shows that Australian consumers are already contributing a larger part of the health bill than their counterparts in most other developed western countries. People are already paying out of pocket expenses for private hospitals, primary care services, PBS medicines, non PBS medicines, dental services and aids and appliances. These out of pocket expenses are on top of additional

[16] As discussed in Doggett Jennifer (2014) Empty Pockets Why co-payments are not the solution, Consumers Health Forum https://www.chf.org.au/pdfs/chf/Empty-Pockets_Why-copayments-are-not-the-solution_Final-OOP-report.pdf

[17] Commonwealth Fund (2013) Comparisons of Health Systems Data, cited in Consumers Health Forum of Australia (2014) Submission to Community Affairs Legislation Committee Inquiry into the National Health Amendment (Pharmaceutical Benefits) Bill 2014. https://www.chf.org.au/pdfs/chf/CHF-Submission_Inquiry-into-PBS-CoPayments.pdf

costs often experienced by people with chronic diseases and disabilities that also generally have lower earning power.

The Committee should also be aware of the short term nature of any financial gain made by a GP co-payment system. The introduction of co-payments, especially at the $15 rate proposed by the Commission of Audit, will likely see people defer seeking healthcare, resulting in more expensive treatments being needed later and / or further overcrowding of emergency departments. All developed countries recognise that spending on prevention, i.e.GPs and related services, is the best way to address hospital overcrowding.

Universal access to health care recognises not only the importance of prevention in terms of health of individuals but the health of the broader community. We are all at risk if people do not gain the healthcare they need the obvious example being contagious diseases.

In addition we all pay the cost if people use more expensive services such as hospital emergency departments or worse they delay receipt of needed health care until their condition has worsened. This concept of 'social solidarity' is recognised in the funding of most health systems across the developed world[18] with the US coming later than most to this understanding with the introduction of the Affordable Care Act.

Conclusion

In conclusion, VMAG generally supports the recommendations for reform by the Senate Inquiry into Out of Pocket Costs. We noting that the COAG Reform Council found that nationally, around 6per cent of Australians already delayed or did not see a GP due to cost. This is particularly the case amongst people living outside major cities (7.2% vs 5.3%) and for women (7.0 % vs 4.3% men). The rate at which people reported cost

[18] European Commission Health Systems Research
http://ec.europa.eu/research/health/public-health/health-systems/index_en.html

barriers to seeing a GP was similar regardless of how socioeconomically disadvantaged the area was in which they lived.[19] This underscores the importance of universal access to help ensure that there are no additional barriers to people getting the health care they need.

We also consider many of the wider proposals for reform put forward by the Grattan Institute in their submission to this Committee deserve support.[20]

For more information on VMAG see: http://vicmedicareactiongroup.weebly.com/

[19] COAG Reform Council (2014) Op cit and cited in Commonwealth of Australia (2014) Out-of-pocket costs in Australian healthcare at para 3.30 http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~/media/commi.

[20] Stephen Duckett & Peter Breadon (2014) Grattan Institute Submission to Senate Select Committee on Health https://www.google.com.au/search?q=Grattan+Institute+Submission+to+Senate+Health+Care+Committee&oq=Gra&aqs=chrome.0.69i59j69i60l3j69i57j69i61.2094j0j1&sourceid=chrome&ie=UTF-8