# Senate Community Affairs Committee Inquiry into out-of-pocket costs in Australian healthcare

# Submission from the Australian Healthcare Reform Alliance (ACHRA)

## Terms of Reference

The out-of-pocket costs in Australian healthcare, with particular reference to:

a. the current and future trends in out-of-pocket expenditure by Australian health consumers;

b. the impact of co-payments on:
    I. consumers' ability to access health care, and
    II. health outcomes and costs;

c. the effects of co-payments on other parts of the health system;

d. the implications for the ongoing sustainability of the health system;

e. key areas of expenditure, including pharmaceuticals, primary care visits, medical devices or supplies, and dental care;

f. the role of private health insurance;

g. the appropriateness and effectiveness of safety nets and other offsets;

h. market drivers for costs in the Australian healthcare system; and

i. any other related matter.

## Submission

### *The current and future trends in out-of-pocket expenditure by Australian health consumers*

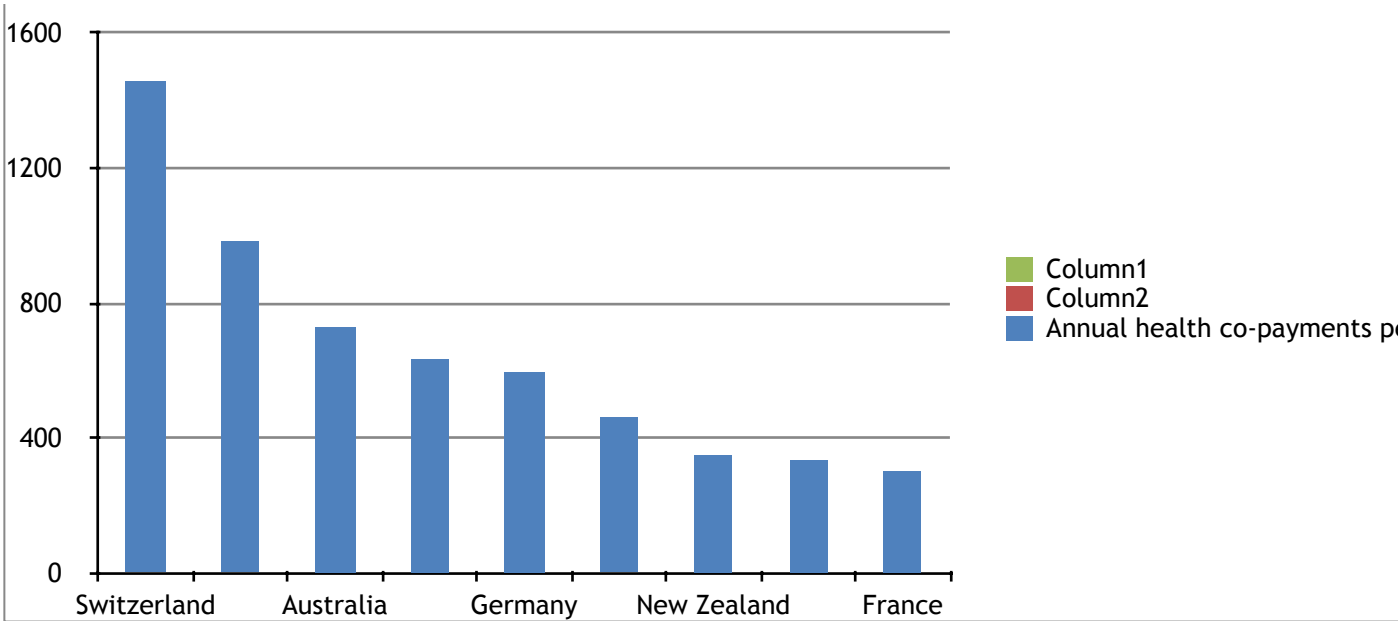
Out-of-pocket payments for health care are the third largest source of health funding after Commonwealth and State/Territory Governments. These payments have increased over the past ten years, both in absolute terms and as a percentage of total health funding. Between 2001–02 and 2011–12, funding by individuals grew by an average of 6.1% a year in real terms, compared with an average of 5.4% for total funding of health expenditure.[1]

Compared with citizens of other countries, Australians pay for a high proportion of their care through out-of-pocket payments. The Commonwealth Fund[2] has found that when health care spending is adjusted for the cost of living, Australians pay more in direct payments than all other countries surveyed, apart from the USA and Switzerland.

**Health co-payments per capita 2011 (adjusted for the cost of living)**

[1] AIHW 2013a

[2] Squires 2013




The growth in out-of-pocket costs over the past decade has occurred in an ad hoc manner without any policy oversight from either the Commonwealth or State/Territory governments. Direct consumer payments for health goods and services have been introduced (and increased) by individual practitioners, retailers and service providers, or on a program basis by governments, without taking into account the overall impact of these costs on consumers. There is also no agreed understanding of the purpose(s) of out-of-pocket costs among policy makers and service providers (for example whether their goal is to raise additional revenue, reduce demand, send price signals to consumers or some other alternative). Therefore it is impossible to assess whether or not out-of-pocket payments achieve their goals and/or if they are the most appropriate mechanism to do so.

Another outcome of this ad hoc approach is that there is an inconsistency across the health system in the way out-of-pocket contributions operate. Some forms of health care remain free at the point of services (for example bulkbilled GP services and most forms of public hospital care) while others require consumers to contribute most or all of the cost (for example over-the-counter medications and many aids and appliances). This results both in inequities among consumers in their access to health care and in inefficiencies in the use of health goods and services, where consumers choose less cost-effective treatment options to reduce their out-of-pocket costs (discussed in more detail below).

**AHCRA recommends:**

- that comprehensive data be regularly collected on the level and source of out-of-pocket payments for health care with a specific focus on people with chronic conditions and disabilities, older people and people on low incomes.
- that a broad consultation process be undertaken on out-of-pocket payments within the health sector, involving all stakeholders (in particular consumers from groups most likely to be affected by payment increases).
- that, on the basis of this consultation process, a comprehensive policy be developed on the role of out-of-pocket payments (if any) within the health system, with input from all stakeholders.

*The impact of co-payments on: consumers' ability to access health care, and health outcomes and costs;*

Australia does not conduct any systematic research or data collection on the overall out-of-pocket payments made by consumers for their health care. This makes it difficult to make definitive statements about the impact of these payments on access to health care and health outcomes. However, there is good evidence from a number of sources that out-of-pocket payments are currently creating barriers to access for some consumers and resulting in an inequitable and inefficient use of health care resources. In particular, the available research suggests that people with chronic conditions, older people and those on low incomes are particularly disadvantaged by out-of-pocket payments for health care.

For example, the Commonwealth Fund's 2013 International Health Systems[3] survey and its 2008 Survey of Sicker Adults[4] found significant evidence that co-payments were creating an access barrier for many consumers. Among the surveys' findings were:

- 16% of Australians surveyed reported delaying access to treatment due to cost issues;
- 29% of Australians reported not accessing dental care in the past year due to cost
- 20% of Australians with a chronic condition reported not filling a prescription in the past year due to cost issues
- 21% of Australians with a chronic condition reported delaying or avoiding seeking medical treatment due to cost issues
- 25% of Australians with a chronic condition reported not having a recommended test or follow-up treatment due to cost issues
- Overall 36% of Australians with a chronic condition reported experiencing a cost barrier to care in the past year

Another study undertaken by the Australian Bureau of Statistics[5] found that almost one in five (18 per cent) Australians aged 15 and over and over one quarter (27 per cent) of Australians in the age group of 25 to 34 years who needed to see a dental professional had delayed seeing or had not seen a dentist due to cost.

These outcomes reflect the findings of international research into health co-payments which has found that out-of-pocket payments reduce access to health care, and that this decrease in access is proportional to the size of the payment but can occur at even very low levels. Population group who have a higher-than-average need for health care, such as older people, people on low incomes and people with chronic illnesses, are the most adversely affected by out-of-pocket payments.

While some studies demonstrate that introducing or increasing co-payments can reduce demand for a specific health service, there is no evidence that this decrease in demand is

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[3] Squires 2013

[4] Schoen and Osborn 2008

[5] Patient Experience Survey, Australian Bureau of Statistics 2012

only for unnecessary or low-value services. In fact, the available evidence suggests that the decrease occurs in both high and low value services. There is also no evidence that out-of-pocket payments result in an overall reduction in the cost of health care. The limited evidence available in this area indicates that in fact out-of-pocket costs may lead to increased downstream health care costs.

Given the Australian and international evidence in this area, ACHRA believes that if the current trend towards increasing out-of-pocket payments continues, more Australians will have difficulties in affording health care. This is likely to lead to an increase in the level of preventable chronic disease in the community and increase existing health inequalities. Over the longer term this will increase the cost of health care to our community.

**AHCRA recommends:** that a moratorium be imposed on new or increased out-of-pocket costs for health goods and services for which the Federal Government has responsibility until comprehensive data has been collected on the impact of existing payments and a policy on out-of-pocket costs has been developed.

### *The effects of co-payments on other parts of the health system*

As noted above, out-of-pocket costs do not occur uniformly throughout the health system. In 2011/12 almost 60% of the $24.8 billion in co-payments for health care were for medicines (39%) and dental services (19%). The next three areas of expenditure were 11.9% for medical services, 10.1% for aids and appliances and 7.8% for other health practitioner services.[6]

In addition to reducing access to care, co-payments interact with other funding systems across the health system. In some cases they can create a perverse incentive to accessing the most cost-effective forms of care. For example, people may seek public hospital treatment for conditions which could have been treated by a community-based practitioner in order to reduce their out-of-pocket costs.

**AHCRA recommends:** that co-payments for health goods and services be introduced only if they support the most cost-effective use of health resources.

### *The role of private health insurance*

Out-of-pocket costs occur in relation to many services funded through private health insurance. Excess and co-payment conditions are included in approximately three quarters of all private health insurance policies held in Australia and in some cases the payments can be significant. PHIAC quarterly statistics for June 2013 show that the average co-payment for one episode of hospital treatment was $307 and for non-hospital services it was $47. Due to their higher average level of need, older people incur higher out-of-pocket payments than younger people when using private health services. AIHW data[7] shows that in 2010-11 people with health insurance aged 65 and over who had a hospital admission spent an average of $1171 on out of pockets for hospital services.

There are a number of problems associated with the role of out-of pocket payments for services funded through private health insurance. Many forms of insurance pay a fixed rebate for services, leaving consumers exposed to potentially unlimited costs. Consumers

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[6] AIHW 2013a

[7] AIHW 2011 Table 3.16 pg 42

who rely on ancillary services often find that their rebates cover less than half of the cost of a visit, with yearly limits imposed on the total benefits paid which can run out quickly for people needing frequent treatment.

Another growing problem in this area is the trend towards developing policies with lower premiums but more restrictions and exclusions for selected forms of treatment and higher co-payments when the insurance is used.[8] The Private Health Insurance Administration Council (PHIAC) reports that in 2012 60 per cent of people took out cover with exclusions, up from 40 per cent in 2003.[9] This results in higher out-of-pocket payments when consumers access care. This can result in consumer dissatisfaction, as indicated by PHIO's report that complaints about exclusions and restrictions have increased in recent years.[10]

**AHCRA recommends:**

- that out-of-pocket costs associated with health care funded via private health insurance be included in regular data collection on out-of-pocket costs for health care (outlined above).
- that research be undertaken into the increasing trend towards 'low premium, high excess' private health insurance policies to determine whether or not they disadvantage some consumers.

### *The appropriateness and effectiveness of safety nets and other offsets*

A number of safety-nets have been introduced to support consumers with higher than average health care costs, including both the PBS and MBS safety-nets. These arrangements help address some of the equity and efficiency problems resulting from out-of-pocket costs but they do not provide adequate assistance to many groups of consumers. In some cases they have an opposite effect to that which is intended by increasing inequities within the health system and discouraging the most efficient use of resources.

Specific problems with the current system of safety-nets include:

- they are administratively complex and place an increased burden on consumers and their families/carers;

- they are inconsistent in their application which creates confusion and reduces their effectiveness. For example, some operate on an individual basis and others on a family basis, some use calendar year outlays and others use financial years.

- they often come into effect only after a significant number of services have been used and so do not address the need for high up-front payments for health care ;

[8] PHIAC 2012a

[9] PHIAC 2012b

[10] PHIAC 2012a

- they often don't support the choice of the most effective or efficient care option (for example people who reach the PBS safety-net will have a greater incentive to seek a pharmacological treatment for their condition, rather than a medical or allied health treatment, even if it is not the most cost-effective);

- they disadvantage people whose have lower level care needs over a longer period compared with those with higher care needs over the short term (as they are often based on annual expenditure);

- they are poorly targeted and miss many people who have difficultly affording their health care costs ;

- they operate in isolation from each other which disadvantages consumers who require multiple forms of health care; and

- they primarily focus on medical treatment and prescription pharmaceuticals and do not address the range of other costs associated with illness and disability.

**AHCRA recommends:** that a single comprehensive safety-net be implemented for all forms of health care, including both public and private services. This should be based on data on the costs of health care and take into account people's capacity to afford health care over the long term.

### *Market drivers for costs in the Australian healthcare system*

AHCRA acknowledges that spending on health care is rising in Australia. However, our level of expenditure on health care is around the OECD average and for that level of spending we obtain above average health outcomes (for example life expectancy). This indicates that our investment in our health system – overall – is delivering good value.

There is also no indication that our trend in health spending is unsustainable. In fact, even if health care expenditure were to rise from 10 per cent of GDP to 20 per cent of GDP between now and 2050, the remaining 80 per cent of GDP in 2050 would still be higher than 90 per cent of GDP in 2013 (unless economic growth slows dramatically).

Therefore, ACHRA believes that instead of focusing on reducing health spending to an arbitrary level, we need to focus on ensuring that our level of spending delivers the best possible value to the community and reflects consumer priorities and concerns. In particular, the policy focus should be on obtaining value from overall expenditure, not simply shifting costs from governments to consumers, in particular where these result in higher overall costs and a reduction in equity.

International evidence demonstrates that the countries with a strong primary health care sector and universal public insurance achieve the best health outcomes for the lowest cost. ACHRA therefore believes that Australia's best chance of ensuring our health system remains sustainable and delivers good value is to continue to invest in a strong primary care sector and to support the continuation of Medicare as a universal insurer. Within this

framework, ACHRA believes there is the potential to improve the efficiency of our health system through a number of different strategies, including workforce reform measures, an increased focus on prevention and a move away from a fee-for-service structure, in particular for primary health care.

### *Any other related matter*

ACHRA has no comments against this term of reference.

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