AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Out of pocket costs in Australian health care

The health financing system in Australia has served Australians well in terms of health outcomes and affordability, as acknowledged in the National Commission of Audit report (chapter 9.3).

There is a general expectation in the Australian community that health care should be 'free' at the point of service. Most Australians oppose paying to see a doctor[1].

The perception in the Australian community that out of pocket costs[2] for health care and in particular for medical services have increased as a proportion of health expenditure, is not supported by data.

A design feature of health care financing

The community must recognise that out of pocket costs are a design feature of Australia's health care financing arrnagements:

- At the commencement of Medicare, the rebate was set at 85% of the Medicare Benefits Schedule (MBS) fee (later changed to 75% for in-hospital services);
- Private health insurers (PHI) are required to pay at least 25% of the MBS fee, and will only cover 100% of costs when the medical practitioner agrees to charge a fee that is equal to the level of benefit set by the patient's private health insurer;
- Pharmaceutical Benefits Scheme medicines were initially free of charge until 1960 when a co-payment of 50 cents was introduced, and is now $36.90 (or $6.00 for concession card holders).

A viable and sustainable health care system relies on private providers being free to set their fees and charges to recoup the cost of providing the service. Safety nets are in place for people who are unable to afford out of pocket costs to ensure they can access care when they need it.

Australian health care safety nets

- The provider accepts the MBS or PHI benefit as full payment;
- Medicare and PBS safety nets after a threshold is reached;
- Public health and hospital services

[1] Consumers Health Forum of Australia. Media release *Medicare co-payment plan a massive concern to voters, new poll finds* 11 May 2014.

[2] In using the term 'out of pocket cost', the AMA also means 'co-payment' and 'gap payment', being the amount of money paid by a health care consumer for a health care service, treatment or product, that is not covered by a Government benefit or program or by their private health insurer.

The high level of acceptance of the MBS or PHI benefit as full payment by medical practitioners contributes to the community perception and/or expectation that their services should be 'free'.

2012-13
81.1% GP consultations bulk-billed
88.7% private in-hospital medical services charged at PHI benefit
Reference: A

The community's understanding of how the health financing arrangements are designed to work may also have changed in 2004 when the Medicare rebates for GP consultations increased to 100% of the MBS fee, and with bulk billing incentives.

Has expenditure on medical services changed over time?

Since 1985, successive governments have applied an annual indexation to MBS fees that has been well below the market indices that have a direct impact on the cost of providing medical services, being the Labour Price Index and the Consumer Price Index.

Medicare benefits coverage of fees charged by medical practitioners
In 1984-85, 90.3%
In 2012-13, 78.4%
Reference B

Together, the MBS and the PHI schedules of medical benefits have moderated the average annual growth in expenditure on medical services to 4% in the decade to 2011-12, less than:

- 5.4% growth in total health spending;
- 6% growth for the PBS; and
- 9.3% growth for products at the pharmacy.

Reference C

The proportion of health expenditure on medical services has not changed over time.

18.8% in 2001-02
18.1% in 2011-12
Reference D

Have out of pocket costs for medical services changed over time?

In the decade to 2012-13, the percentage of medical services attracting out of pocket costs has either stayed the same or declined. The medical profession has effectively absorbed the relative reductions in Government and PHI contributions to the cost of medical services. However, patients who do have out of pocket costs for medical services are paying more today than they were a decade ago. These services partly offset the services provided at no cost.

Service	Percentage of services with an out of pocket cost		Average out of pocket cost		Average growth per annum
	2002/03	2012/13	2002/03	2012/13	
VR/GP attendances	31.3%	18.9%	$12.46	$28.58	11.8%
Other medical practitioner attendances	21.8%	14.6%	$22.18	$53.91	13.0%
Specialist attendances	72.2%	71.3%	$27.99	$57.03	9.4%
Operations*	61.7%	60.1%	$28.28	$70.84	13.7%
Anaesthesia*	90.7%	90.8%	$68.55	$111.10	5.6%
Diagnostic imaging	40.6%	25.2%	$43.57	$88.02	9.3%
Pathology	16.0%	12.8%	$11.59	$22.91	8.9%
Privately insured in-hospital	19.00%	11.30%	$96.01	$181.76	8.1%

** % of privately insured in-hospital services with a gap are significantly lower.*
Reference E

Health consumers are generally not aware that the Government and PHI schedules of benefits (and indexation) are unilaterally determined by them. The high rates of schedule fee observance by medical practitioners is rarely if ever acknowledged, let alone applauded, by Government or PHIs. Instead, consumers are led to believe that schedules reflect appropriate fees, and out of pocket costs are blamed on "doctors charging too much".

Some PHIs directly cause high out of pocket costs by precluding any patient co-payment as a qualification for the higher 'no-gap' benefit and only paying 25% of the MBS fee. Consumers[3] are generally unaware that there is a two-tier level of PHI benefit for medical services.

In addition, consumers are increasingly purchasing PHI products that require out of pocket costs.

	June 2008	**June 2013**
Exclusionary policies	12.4%	24.7%
Excess and co-payments	72.5%	78.1%

Reference F

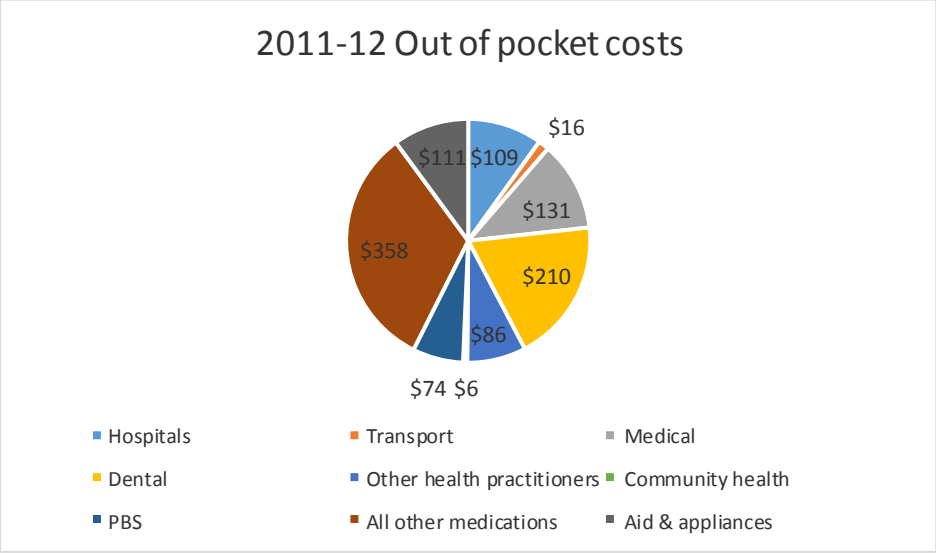
These factors all contribute to the perception that there is a problem with out of pocket costs for medical services, when in fact they are decreasing as a percentage of services provided.

Where are out of pocket costs incurred?

Consumers' out of pocket costs have not changed as a proportion of total health expenditure.

In 2001-02, 17.5%
In 2011-12, 17.3%
Reference G

Contrary to common perceptions, medical services do not make up the majority of out of pocket costs for individuals. They account for 11.9% of the total of individuals' out of pocket costs.



Reference H

[3] Who contact the AMA about medical fees.

The majority of out of pockets costs are in the 'All other medications' category, which is the largest proportion and highest growth item.

What is the impact of out of pocket costs on consumers?
While a large proportion of episodes of health care are at no cost to the patient, the AMA recognises that Australian health care consumers are concerned about the out of pocket costs that they experience.

The Consumers Health Forum of Australia presented a well-rounded consumer perspective on the impact of out of pocket costs in April 2013 in its edition of Health Voices *Australian healthcare – out of pocket and out of date*?

The AMA supports good informed financial consent practice by medical practitioners. Providing information to patients in advance of the likely financial implications of proposed treatment is sound ethical, professional and business practice.

Clinical impacts
The Australian Bureau of Statistics *Health Services: Patient Experiences in Australia, 2009* states that 6% of Australians delayed seeing or did not see a GP in the previous year because of the cost. Importantly, there was no significant difference between people living in more disadvantaged areas and those in less disadvantaged areas, nor was there any particular difference between major cities, inner regional and outer regional/remote areas of Australia.

Hynd et al[4] observed that, following an increase in the PBS co-payment in January 2005, there was a significant decrease in dispensing volumes in 12 of 17 medicine categories – anti-epileptics, anti-Parkinson's treatment, combination asthma medicines, eye drops, glaucoma treatment, osteoporosis treatment, proton-pump inhibitors and thyroxine. All of these medications seek to maintain a patient's condition, improve function and quality of life, prevent complications and reduce morbidity and mortality. Hynd also found that social security beneficiaries were particularly impacted by the increase in the co-payment.

A literature review by Eaddy et al[5] identified clear relationships between cost sharing, adherence, and outcomes, with 85% of the reviewed studies on treatments for diabetes, cardiovascular, mental health and pulmonary conditions showing that an increase in patient share of medication costs was significantly associated with a decrease in adherence. They concluded that plans by decision makers to increase the level of patient cost sharing for prescription drugs to slow the rising cost of health care may be short-sighted and counterproductive because increases in medical utilization due to poorer outcomes may outweigh the savings from lower prescription drug use.

In reviewing four decades of research on cost-sharing, Machledt and Perkins[6] identified consistent conclusions that the imposition of cost sharing on low-income and vulnerable

[4] Hynd A, Roughhead EE, Preen DB, Glover J, Bulsara M. Semmens J. *The impact of co-payment increases on dispensing of government-subsidised medicines in Australia.* Pharmcoepidemiology and Drug Safety 2008 Nov, 17(11):1091-9
[5] Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR *How patient cost-sharing trends affect adherence and outcomes.* Pharmacy and Therapeutics Vol 37 No. 1 January 2012
[6] Machledt D, Perkins J *Medicaid Premiums and Cost Sharing* National Health Law Program. March 2014 http://www.nationaldisabilitynavigator.org/wp-content/uploads/resources-links/NHeLP_IssueBriefMedicaidCostSharing_03262014.pdf

populations reduces both necessary and unnecessary care and correlates with increased risk of poor health outcomes. They also identified that cost sharing policies do little to increase overall cost efficiency, and that their effect on the overall rate of growth in health care spending is complex, difficult to measure, and likely rather limited. They attributed this in part to the fact that health expenditures are extremely concentrated in the sickest patients whose total expenses are little affected by cost sharing policies.

Sustainability of the health system

Out of pocket costs are a feature of the Australian health financing system. They are not growing at a faster rate than other health costs. The evidence does not support the assumption that increased out of pocket costs will help to reduce overall health expenditure.

The 2014-15 Federal Budget measures shift costs to patients through:

- co-payments for GP services;
- co-payments for emergency departments;
- higher co-payments for medicines;
- cuts to Medicare rebates;
- frozen rebates for specialist services; and
- revised Medicare safety net arrangements that will not provide sufficient protection.

There is now much Australian data that identify the volume of treatment provided during episodes of care is the most significant driver of rising health care costs – the most recent being the Grattan Institute report *Budget pressure on Australian governments: 2014 edition* (page 20).

Australia must change the way it provides health care, where it provides care, and when it is provided for the major driver of health care costs.

With the rapid increase in medical knowledge and the rate of change of best practice care, evaluation and change must be a feature of the health care system, not an after- thought.

The need to invest in a healthier future with better disease management, and prevention of avoidable costly hospital admissions, informed by data and research, is obvious.

Contact

Belinda Highmore
Director, Medical Practice
Ph: (02) 6270 5439

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Reference H: Australian Institute of Health and Welfare. *Health expenditure Australia 2011-12*. Table 3.11.