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9 May 2014

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

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Dear Secretary,

Re: Senate Community Affairs Inquiry – Out-of Pocket costs in Australian healthcare

The Royal Australian College of General Practitioners (RACGP) thanks the Senate Community Affairs Committee for the opportunity to contribute to discussions regarding Out-of-Pocket costs in Australian healthcare.

The RACGP believes the concept of 'co-payments' or 'out-of-pocket expenses' is a poor solution to reducing or arresting costs of Australian healthcare. It is preferable for the government to look at long-term solutions, in order to create an equitable, high quality and efficient healthcare system.

The RACGP respectfully encloses its submission regarding this important inquiry and hopes that the recommendations made will assist the Committee in its considerations regarding the Out-of-Pocket costs in Australian healthcare. The College considers its submission to be in the public domain at the Committee's pleasure.

If you have any questions or comments regarding this submission, please contact me or Mr Roald Versteeg, Manager – Policy & Practice Support

Yours sincerely

Dr Liz Marles
President

Encl. Submission to Senate Community Affairs Reference Committee

RACGP

RACGP Submission to the Community Affairs References Committee

Out-of-pocket costs in Australian healthcare

Published by

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Overview of RACGP Senate Inquiry Submission

Introduction

Senate Inquiry

The Royal Australian College of General Practitioners (RACGP) thanks the Community Affairs References Committee for the opportunity to contribute to the discussion regarding out-of-pocket costs in Australian healthcare.

The RACGP believes the inquiry is timely and will help facilitate important discussion between government, the health profession and patients regarding funding for a health system that supports equity of access, quality and efficiency.

About the RACGP

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners (GPs) in their pursuit of excellence in patient care and community service.

RACGP Submission to Senate Inquiry

The RACGP notes the Senate Committee's terms of reference, including:

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 healthcare

   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

i. any other related matters.

Within the context of the terms of reference, the RACGP's submission primarily focusses on general practice funding and the impact of these funding arrangements on the health system more broadly. The submission covers the following areas:

1. The current system – designed for the outcomes it achieves.
2. Australia's out-of-pocket expenses.
3. General practice co-payments – a solution to a problem that doesn't exist.
4. Co-payments – a poor instrument for controlling costs.
5. The potential role of private health insurance in general practice.
6. Realigning the healthcare system to support quality and efficiency.

1. The current health system – designed for the outcomes it achieves

1.1 Designed to drive hospital presentation and admission

Despite the efforts of both state and Federal governments, the delivery of patient services in Australia is under strain. The cost of Australian healthcare continues to increase for health funders and individual patients, failing patients, healthcare providers and funders alike.

However, it is important to note that the Australian health system delivers what it is designed to deliver – hospital presentation and admission. The cost of healthcare continues to rise because the Australian health system delivers what it has been designed to achieve – patients relying on emergency department and hospital use.

1.2 Health system costs

Australia spends more than $140 billion on healthcare per year, accounting for almost $1 for every $10 the nation spends.[1] Even more concerning is the fact that health spending grew by nearly 70% in the last 10 years, increasing GDP expenditure on health costs by more than 1%.[2]

Table 1. Comparison of health expenditure: 2001–02 and 2011–12[2,3]

	2001–02	2011–12	Percentage increase
Percentage of GDP	8.4%	9.5%	11.3%
Recurrent expenditure per person*	$4276	$6230	45.7%
Average GP out-of-pocket expenses†	$11.68	$27.65	136.7%

* Expenditure is constant. The 2001–02 expenditure is expressed as terms of 2010–11 figures (AIHW, Health Expenditure in Aus 2010–11 p.14).
† Average out-of-pocket expenses per patient consultation, not removing bulk-billed amount.

Hospital spending represents the largest area of overall health spending and growth, rising by 4.9% in real terms (adjusted for inflation) per year for the last 10 years[4] and representing more than 40% of overall health expenditure.[5]

The Australian hospital sector, within the current constraints imposed, does an excellent job in delivering health services for all people residing in Australia. Notwithstanding this, many services delivered in hospitals are wasteful in terms of health spending, as the services can be safely and efficiently delivered in primary healthcare at a fraction of the cost. Example areas include, but are not limited to:

- minor medical procedures
- pain management
- anti-coagulant screening and management
- wound management.

Table 2. Comparison of cost between general practice and hospital (examples)[6,7]

	Hospital	General practice	Difference $
Preaneasthetic assessment and evaluation	$291.59 IHPA: 20.02	$72.75 MBS: 17615	$218.84
Antenatal care	$222.69 IHPA: 20.40	$47.15 MBS: 16500	$175.54
Sexual health	$252.64 IHPA: 40.10	$70.30 MBS: 36	$182.34
Venesection	$438.39 IHPA: 10.13	$72.95 MBS: 13757	$365.44
Skin biopsy	$289.09 IHPA: 20.33	$62.90 MBS: 23 & 11700	$226.19
Wound management	$162.27 IHPA: 40.13	$36.30 MBS: 23	$125.97

As demonstrated in *Table 2* above, many hospital services and procedures are currently between four and seven times more than the cost of the equivalent general practice service.[6,7] However, the health system drives patients to use the hospital system for healthcare that could be provided within the general practice setting.

Essentially, high patient co-payments are driving hospital emergency department use and a dependency on hospitals for health needs. This is resulting in higher health costs and poorer outcomes for the health system.

2. Australia's out-of-pocket expenses

2.1 Out-of-pocket expenses – on the rise

According to the Australian Institute of Health and Welfare (AIHW), patient out-of-pocket expenses for primary healthcare have significantly increased over the past 10 years, rising from $9.7 billion in 2001–02 to $17.1 billion in 2011–12, representing a 76% increase.[5]

The overall share of patient out-of-pocket expenses in primary healthcare expenditure also increased from 31.6% in 2010–11 to 33.9% in 2011–12 – a 10.7% increase for families and individuals.[5]

2.2 Impacting access and delaying healthcare delivery

According to the Australian Bureau of Statistics, around 82% (14.5 million) of Australians aged 15 years and older visited a GP at least once in the past year in 2010–11.[8] However, around 1.8 million Australians (approximately 8% of the population) also indicated that they delayed or avoided seeing their GP because of cost.[8]

If out-of-pocket expenses continue to rise, the already substantial number of Australians avoiding or delaying seeing their GP will also rise, resulting in a decrease in health service accessibility and poor efficiency of services.

A recent report by the National Health Performance Authority (NHPA) demonstrates that bulk-billing rates vary from as low as 49% in some Medicare Local districts to as high as 95.8% in others.[9]

Out-of-pocket expenses and their impact vary from region to region, but they are increasing overall[5] and, as a result, many more families and individuals are facing higher healthcare costs relative to income. These people are increasingly delaying or avoiding general practice care due to cost. This in turn drives unnecessary emergency department use, with patients either:

- arriving at hospitals for care that could be delivered at a significantly lower cost in the general practice setting, or
- being admitted to hospital for conditions that could have been treated outside of the hospital setting at a fraction of the cost if they had been managed earlier.

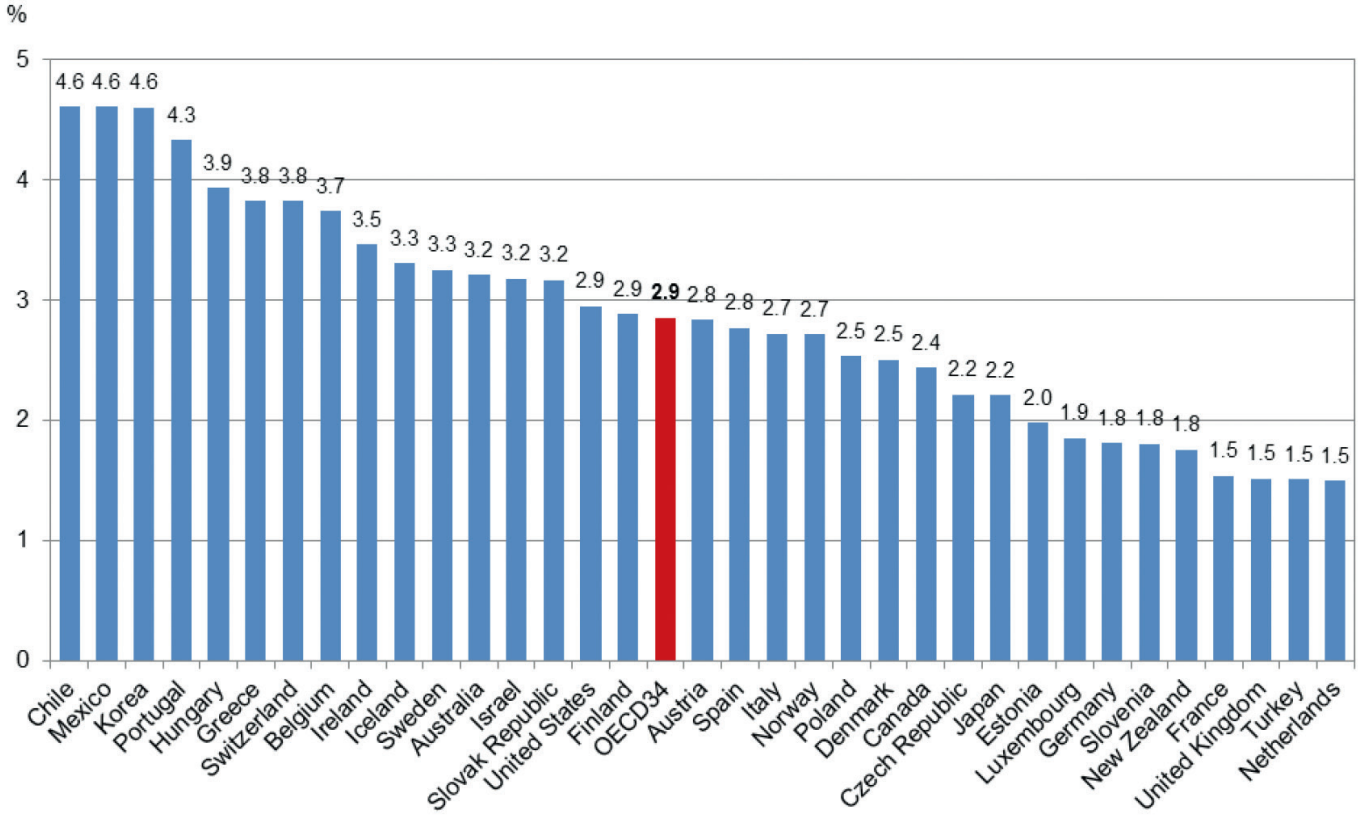
It is estimated that Australia spends almost $1 billion annually on avoidable hospital costs.[1] It is therefore not surprising that Australia ranks poorly in this area when compared to other health systems around the world. According to the OECD, Australia ranks above the average number of avoidable hospital admissions per 100,000 people for two of the three long-term conditions reported on in 2011.[10]

2.3 Comparative to other OECD nations

In terms of out-of-pocket expenses comparative to other OECD nations (see *Figure 1* below), Australia performs quite poorly – notably above the OECD average.[10]

Out-of-pocket expenses are not an effective tool in controlling health spending and must be addressed as a priority. See *Section 4* for further details.

Figure 1. Out-of-pocket medical spending as a share of final household consumption 2011[10]



3. A solution to a problem that doesn't exist

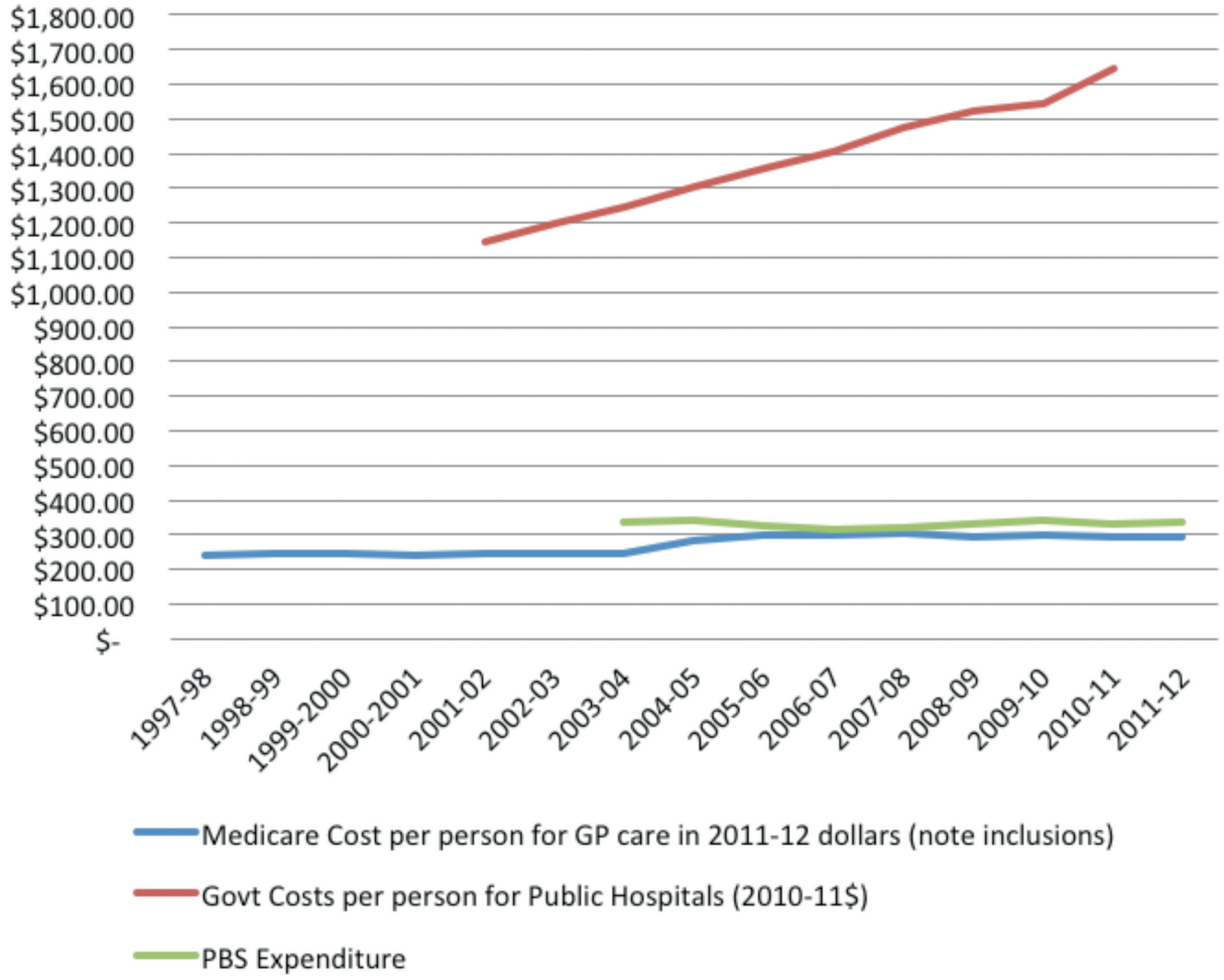
Discussion regarding the need for co-payments in general practice is both ill considered and ill advised.

3.1 No 'ballooning' of general practice costs

Co-payments for general practice are a solution to a problem that doesn't exist.

As demonstrated by the Productivity Commission, despite increasing health costs in relation to hospital expenditure, health costs per person for general practice services (as depicted in *Figure 2*) have remained relatively steady since 1998, particularly when compared to hospital costs over a similar period of time.[11]

Figure 2. Comparative‡ health costs per person per year 2011–12[11]



‡ Notes: General practice expenditure in *Figure 2* includes consideration of the Medical Benefits Schedule, GP Practice Incentive Payments, and general practice dvision/Medicare Local funding.

3.2 Delivery of general practice care – the most efficient component of the health system

From an overall health sector perspective, hospital expenditure is the greatest cost and the greatest area of growth, continuing to rise over the last 10 years. Conversely, general practice costs and Pharmaceutical Benefits Scheme (PBS) costs have remained stable (in real dollar terms) over the past 20-plus years.

These data demonstrate a key issue in health sector funding. Despite the rhetoric regarding GP fee-for-service in general practice 'driving' increased expenditure, the facts demonstrate that funding for GP fee-for-service has remained stable.

Essentially, there is no 'ballooning' of general practice costs. General practice remains one of the most efficient components of the health system and patients should be encouraged – rather than discouraged – to see their GP.

4. Co-payments – a poor instrument to controlling costs

The RACGP, like many bodies, including government departments, believes the concept of 'co-payments' or 'out-of-pocket expenses' is a poor solution to reducing or arresting cost. Many governments believe expenditure can be curbed by imposing costs on families and individuals, with co-payments seen as a 'price signal' to discourage use. This is despite the fact most countries are moving away from using co-payments as a means of curbing cost and financing healthcare.[12]

Despite Medicare safety nets and other mechanisms designed to protect people from excessively high out-of-pocket costs, the evidence demonstrates (see *Section 2.2*) that the cost of care is stopping people from using necessary health services, which is neither equitable nor efficient.[8] 'Price signals' are only useful to discourage discretionary spending, not necessary spending like healthcare.

The RACGP is particularly concerned that mandatory co-payments in general practice, regardless of the quantum, will impact on patients with the greatest healthcare need, including:

- Aboriginal and Torres Strait Islander peoples
- elderly patients
- people in lower socioeconomic areas and those with very low incomes
- other healthcare card holders and people in need.

For Aboriginal and Torres Strait Islander peoples, the proposed co-payments seem counter-productive to the Close the Gap initiative, which has been supported by successive governments over a number of years.

It is important to note that the RACGP is not against all co-payments, but is against co-payments that impact on accessibility for required care, particularly 'mandatory' co-payments, as is being proposed. As has been previously raised in this submission, patients delaying or avoiding seeing their GP will result in higher healthcare costs in the long-term, as conditions are exacerbated due to a lack of treatment. If the government is serious about creating a quality and efficient health system, 'system-wide' co-payments should be abandoned as a solution.

Essentially, general practice is not the problem and co-payments are not the solution.

5. The potential role of private health insurance in general practice

The RACGP believes discussion around the role of private health insurance should be separate from discussion regarding co-payments, as the two concepts relate to distinctly different issues.

Notwithstanding the above, given private health insurance is part of the Senate Committee's terms of reference, the RACGP provides the following comment.

5.1 Opportunity to support quality and efficiency

The RACGP believes that, under strictly agreed conditions, there is a possible role for private health insurers to support the delivery of general practice services that are not currently funded by Medicare. The RACGP does not support amendment of the *Private Health Insurer Act 2007*.

However, if well designed there is opportunity for private health insurers to support health system efficiency, reducing admissions and keeping patients out of hospital through:

- preventive healthcare, including information, advice and health checks
- targeted chronic disease management and hospital avoidance programs (eg. hospital in the home and integration of care)
- other support for GPs and general practices to flexibly meet the needs of their patients, supporting local solutions to local challenges.

5.2 Underpinning principles

To ensure people residing in Australia are not disadvantaged by possible changes to private health insurance arrangements in general practice, and that we continue to support equity of access for all people regardless of income, the RACGP believes any model involving private health insurers must:

- Not interfere with a patient's usual GP – private health insurance must not require or encourage patients to see 'preferred GP providers' on the basis of the GP's or general practice's participation in a private health insurance program. When choosing a GP or a general practice, patients should be free to make their decision based on quality of care, access, convenience and other preferences. Patients should not be influenced by the GP's participation or non-participation in a private health insurance program.
- Recognise and support the clinical independence of GP decision making – private health insurers must not require or encourage GPs to refer patients to certain providers of care on the basis of their participation in a private health insurance program. Similarly, GPs should not be required to adhere to rules and regulations regarding treatment options for individual patients specified by a private health insurer. GPs must be able to refer patients to other providers of care and provide treatment as clinically appropriate, based on the GP's professional judgement and the individual needs of the patient.

- Support equity of access – patients in Australia can currently access general practice services within a universal health system, regardless of private health insurance status or income. Any general practice private health insurance scheme must not create a two-tiered health system in which patients with private health insurance are given priority or preference to access GP services over those patients who do not have and/or cannot afford private health insurance.
- Provide a safety net for patients who can least afford healthcare – there must be means-tested cover similar to what is offered by private health insurers in general practice.
- Support the medical home – the GP-led medical home facilitates partnership between individual patients, their GP and the extended healthcare team, allowing for better targeted and effective coordination of clinical resources to meet patient need. Any proposals for private health insurance must support the GP-led medical home model.

5.3 A separate discussion for the role of private health insurance

As previously identified, the RACGP believes this is a separate discussion to out-of-pocket expenses and recommends there be follow-up and open discussion with the profession and patients about how private health insurance can support the delivery of quality and efficient patient services in the future.

6. Solutions – realigning the healthcare system for quality and efficiency

6.1 Curbing cost and supporting quality

The major driver of health costs within the Australian healthcare sector is hospital presentation and admission.

Investment in general practice and primary healthcare, combined with zero to low patient co-payments, particularly for low income earners, is the solution.

Targeted and planned funding will:

- increase primary healthcare capacity
- drive patients to present at general practices for healthcare
- curb avoidable hospital presentation and admission
- improve the delivery of healthcare through service expansion, better targeting, care coordination and appropriate escalation of care.

Increased primary health capacity and improved services will result in cost savings through reduced hospital presentations, admissions, length-of-stay and re-admissions.[13–26]

6.2 Funding for general practice and primary healthcare

As identified in *Section 1* of this submission, health systems deliver what they are designed to deliver. Whilst GP fee-for-service has served Australian well, it remains stable and should continue to be the cornerstone of general practice funding, it does not fully support the delivery of a range of quality patient services.

Current barriers to the delivery of quality patient services include:

- inadequate recognition of service complexity in general practice
- inadequate recognition and support for the work required for patients with multiple morbidities and patients with comorbidities
- inadequate recognition of the potential preventive health measures that practices and practitioners could provide
- inadequate and misaligned practice funding
- uneven distribution of workforce for both rural and remote, and socioeconomic status.

There must be additional funding to support services that address the barriers discussed above. Additional funding that supports quality and efficient patient services will allow the government to support the healthcare system that Australians need, while also curbing health spending.

Ultimately, a high performing primary healthcare sector will address the health system failure and is a cost-effective and efficient way to address the needs of government, healthcare providers and patients.

6.3 'Affording' investment in the delivery of general practice services

The RACGP recognises that there are limited dollars available for investment in the current fiscal environment. It is therefore understandable that there may be a temptation to look at short-term solutions to curb immediate cost.

However, the RACGP believes the government must look at long-term solutions to create an equitable, quality and efficient health system, rather than strategies that save minimal dollars in the short-term and result in increased costs over the long-term.

It is not a case of being unable to afford investment in general practice, but rather a case of being unable to afford a lack of investment.

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