Chapter 3
Co-payments

Introduction

3.1 When accessing particular services in the healthcare system, individuals contribute to the financial cost of those services—in the form of a co-payment. However, a number of services are also provided to individuals 'free' at the point of service delivery—that is, no co-payment contribution is required.

3.2 This chapter discusses the following terms of reference:

> (b) the impact of co-payments on consumers' ability to access health care, and health outcomes and costs;
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> (c) the effects of co-payments on other parts of the health system; and
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> (g) the appropriateness and effectiveness of safety nets and other offsets.

Medicare and Pharmaceutical Benefits Scheme co-payments

3.3 The introduction of a Medicare co-payment and an increase in the PBS co-payment were discussed by the National Commission of Audit (the Commission) in its report into Government expenditure released in February 2014.[1]

3.4 In the 2014–15 Budget, the Australian Government announced a range of health initiatives including: a new Medicare Safety Net and changes to the Pharmaceutical Benefits Scheme Safety Net, establishment of a Medical Research Future Fund, and pausing of the thresholds for the Private Health Insurance Rebate and most Medicare fees.

3.5 The Budget also announced the introduction of a $7 Medicare co-contribution or co-payment. From 1 July 2015, bulk-billed patients will be required to pay $7 per visit toward the cost of general practitioner consultations, and out-of-hospital pathology and imaging services.[2] Under the proposed changes, $5 will be invested in the Medical Future Research Fund and $2 will be paid directly to the doctor or service provider. Medicare rebates for items attracting a patient contribution will be reduced by $5.

3.6 The Government has indicated that doctors will be paid a 'low gap incentive payment' to encourage them to charge concession card holders and children under 16

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1 National Commission of Audit, *Towards responsible government. The report of the National Commission of Audit, Phase One*, February 2014, pp 99–100; 111–112.

2 Commonwealth of Australia, *Budget Overview*, p. 13. Also see: The Hon. J.B. Hockey MP, Treasurer, *Budget Speech 2014–15*, 13 May 2014, p. 8.

no more than a $7 patient contribution for their first 10 visits, and to bulk bill these patients (after 10 initial visits) and not charge them for subsequent visits.[3]

3.7 Currently, the incentive payment for bulk-billing concession patients is $6 for metropolitan areas and $9.10 for regional areas and Tasmania. GPs do not receive an incentive payment when bulk-billing patients without a concession card.[4]

3.8 Evidence provided to the inquiry by the Royal Australian College of General Practitioners (RACGP) explained the proposal as follows:

> The current reality is that, if I bulk-bill someone who is a concession card holder or a child under 16—they are seen as vulnerable groups who are likely to be most affected by fees—I am also paid a bulk-billing incentive payment. It is $6 in metropolitan areas, and in some rural areas and areas of workforce shortage it is $9. Effectively, in this new system, if I waive the co-payment and I bulk-bill, my rebate will be reduced by $5 because that is what they are paying and that bulk-bill incentive is lost. So that will be a decrease of between $11 and $14, and on a standard consultation that represents a 25 to 31 per cent reduction in the Medicare rebate, which has only increased from about $22 to $36 over a 20-year period anyway. So, as it is, it is a fairly low rebate.[5]

3.9 In the Budget, the Government also announced that from 1 July 2015, general patients will pay an extra $5.00 towards the cost of each PBS prescription. Patients with a concession card will pay an extra $0.80 towards the cost of each PBS prescription.[6]

3.10 Submissions made to the inquiry prior to the budget announcement commented on the potential introduction of the Medicare co-payment, whereas submissions made after 13 May 2014 referred to the announced measure. In either case, submitters overwhelmingly did not support the introduction of a Medicare co-payment.

3.11 Similarly, the committee received submissions which included comments on the potential increase to the PBS co-payment. Submitters overwhelmingly did not support an increase in the PBS co-payment.

3.12 The majority of the evidence provided to the committee discussed co-payments in the context of the proposals announced in the Budget. This chapter will present the evidence about the impact of co-payments on access to health care and then the evidence received about the impact on health outcomes and costs.

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3 Department of Health, *Strengthening Medicare*, June 2014, http://www.health.gov.au/internet/budget/publishing.nsf/content/budget2014-factsheet-strengthening-medicare (accessed 7 August 2014).

4 Department of Health, *Strengthening Medicare*, June 2014, http://www.health.gov.au/internet/budget/publishing.nsf/content/budget2014-factsheet-strengthening-medicare (accessed 7 August 2014).

5 Dr Liz Marles, *Committee Hansard*, 3 July 2014, p. 16.

6 The Budget also included proposed changes to the Medicare and PBS safety nets which will be discussed in more detail in chapter 4 of this report.

3.13 In order to provide some context for the discussion about the impact of co-payments, this next section will discuss the rationale and effectiveness of the proposed co-payments as well as the issue of price signals in healthcare.

Rationale for co-payments

3.14 Several submitters questioned whether a strong case had been made to justify the introduction of a co-payment, in particular the justification that a co-payment was necessary to reduce the number of visits individuals make to GPs unnecessarily.

3.15 The Tasmanian Council of Social Service observed:

> The aim to "send messages" to people who access the GP unnecessarily is, at best, a risky healthcare strategy. It is the role of GPs to ascertain the severity of symptoms, injuries and illness. To place the burden of this onto unqualified members of the public is irresponsible and unrealistic. To send a message that says "stay home unless you are acutely unwell" will result in presentations to the GP that are beyond the preventative stage.[7]

3.16 The Australian Council of Social Service (ACOSS) submitted that they have not seen any compelling evidence to support the introduction of a co-payment for GP services and that the proposals presented provide no evidence of over-servicing. Furthermore, there has been no analysis presented of the administrative costs of the co-payment schemes.[8]

3.17 Witnesses noted that evidence to suggest that GP over-servicing occurs is limited.[9] Furthermore, defining what may constitute an 'unnecessary visit' is very difficult as individuals are not in the best position to determine the nature and seriousness of their health concern. It is difficult for individuals to make an accurate assessment about the level of medical intervention that may be required and the urgency. Gaining an understanding or making a judgement about whether the 'right' patients are not accessing or delaying using services is also very difficult to do.[10]

3.18 Several witnesses commented that national data reporting the severity of illnesses or symptoms individuals may have when they delay or defer visiting a GP is not routinely collected and is unavailable.[11]

3.19 The Pharmacy Guild of Australia (Pharmacy Guild) submitted details from a 2008 study commissioned by the Australian Self Medication Industry which found that 15 per cent of all GP consultations involve the treatment of minor ailments and 7 per cent involve the treatment of minor ailments alone. The Pharmacy Guild projected

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7 Tasmanian Council of Social Service, *Submission 67*, p. 4.

8 Australian Council of Social Service, *Submission 61*, p. 10.

9 See for example. Dr Liz Marles, *Committee Hansard*, 3 July 2014, p. 20; Ms Rebecca Vassarotti, *Committee Hansard*, 3 July 2014, p. 51.

10 See for example, Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, pp 31–32.

11 See for example, Mr Adam Stankevicius, *Committee Hansard*, 29 July 2014, p. 6; Professor Brian Owler, *Committee Hansard*, 29 July 2014, p. 27; Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, p. 30.

these figures nationally and suggested that this finding equated to 25 million GP consultations annually.[12]

Price signals in healthcare and the effectiveness of co-payments

3.20 The committee notes that the purpose of a co-payment is to create a price signal for consumers to encourage greater consideration of the need to access particular health services, with a view to reduce the number of health service visits.

3.21 Professor Stephen Jan, Professor of Health Economics, The George Institute for Global Health questioned whether such price signals are appropriate given that healthcare is very different from other consumption goods:

> When we are talking about health care, we go to the doctor. The doctor is the provider of health care, but they are also acting as the agent for the consumer—so they help the consumer decide on what health care, further down the track, they will need. Consumers go into this whole—I suppose—'transaction' as an ill-informed individual. The problem with a co-payment is that you are preventing people from even engaging in that first step in getting information about what health care they need.[13]

3.22 The Department of Health submitted:

> Basic economics suggests that, other things being equal, increased prices lead to decreased demand, with the strength of this relationship being referred to as elasticity of demand. However in real world situations, particularly in health, other factors are not equal, and the relationship can be quite complex. In particular, demand is also influenced by income, and for superior goods like health, demand can be very elastic and grow faster than incomes. Moreover, not all health interventions have the same value and changes in aggregate demand may not impact on health outcomes if they reflect a 'swapping out' of less effective interventions for more effective interventions.

3.23 The Royal Australian College of General Practitioners provided the following evidence:

> The federal government's proposed co-payment model is intended to reduce unnecessary general practice health service use. However, international studies demonstrate that, with the exception of the most vulnerable patients, there is limited evidence that co-payments actually reduce health service use. The economic rationale for implementing co-payments is further confounded by evidence suggesting that healthcare costs increase due to preventable conditions not being treated and poorer control of chronic disease and greater hospitalisations.[14]

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12 Pharmacy Guild of Australia, *Submission 41*, p. 13.

13 Professor Stephen Jan, *Committee Hansard*, 3 July 2014, p. 2.

14 Dr Liz Marles, *Committee Hansard*, 3 July 2014, p. 15.

3.24 The Grattan Institute acknowledged that increasing out-of-pocket costs will succeed in its intended outcome to reduce service use. The fundamental issue with encouraging a reduction in medical service use is that:

> …the more that so-called necessary services are reduced, alongside unnecessary ones, the worse the outcome will be. There could be health consequences and increased long-run costs.[15]

Impact of co-payments on consumers ability to access health care

3.25 The Department of Health advised that it is estimated that the introduction of a GP co-payment will result in a one per cent reduction in the rate of growth in GP consultations—the rate of growth will reduce from approximately 4.5 per cent to approximately 3.5 per cent. If the rate of growth is 3.5 per cent, it is estimated that there will be one million fewer GP consultations than there would have been under current conditions.[16]

3.26 However, evidence to the inquiry emphasised that rather than discourage 'over-servicing' and reducing the number of 'unnecessary visits', the introduction of co-payments would have a negative impact on consumers' ability to access necessary primary health care services. This section will first present the evidence received about the impact on access to particular services in the health system and then discuss the evidence received about the impact on access to health care overall, as well as the impact on particular communities.

3.27 The committee also notes evidence received which expressed concern that the introduction of a co-payment will impact on the nature of visits to the GP, by placing additional financial pressure on GPs to see more patients (resulting in shorter consultations) or shifting the focus of the consultation to discussions around capacity to pay rather than on important health discussions.

Access to medical services

3.28 Submitters and witnesses expressed concern that an increase in out-of pocket costs in the form of a co-payment for GP services would result in people delaying seeking medical treatment. It was noted that existing out-of-pocket costs already cause people to delay seeking treatment for financial reasons and that further increases to out-of-pockets costs would exacerbate this situation.[17]

3.29 The RACGP noted Australian Bureau of Statistics findings that in 2010–11 approximately 1.8 million Australians indicated that they delayed or avoided seeing their GP because of cost. The RACGP expect this number to increase if out of pocket costs continue to rise.[18]

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15 Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, p. 29.

16 Mr Richard Bartlett, *Committee Hansard*, 29 July 2014, pp 58–59.

17 See for example, Australian College of Nursing, *Submission* 15*;* Ms Rebecca Vassarotti, *Committee Hansard*, 3 July 2014, p. 55; Ms Jill Gallagher, *Committee Hansard*, 3 July 2014, pp 55–56.

18 Royal Australian College of General Practitioners, *Submission 20*, p. 3.

3.30 In its review of healthcare in Australia, the COAG Reform Council found that nationally, in 2012–13, 5.8 per cent of people delayed or did not see a GP due to cost. The rate was higher outside major cities (7.2 per cent compared to 5.3 per cent in major cities) and for women (7.0 per cent compared to 4.3 per cent for men). The rate at which people reported cost barriers to seeing a GP was similar regardless of how socioeconomically disadvantaged the area was in which they lived.[19]

3.31 The 2012–13 Patient Experience Survey conducted by the Australian Bureau of Statistics reported similar findings. In 2012–13, 5.4 per cent of people reported that they delayed or did not see a GP due to cost.[20]

3.32 The National Health Performance Authority (NHPA) drew the committee's attention to data from their report *Healthy Communities: Australian's experiences with primary health care in 2011–12*. In this report, the NHPA compared Medicare Local catchments on the basis of health status, cost barriers and expenditure of GPs. This report found that in 2011–12, the percentage of adults who reported they delayed or did not see a GP due to cost varied across Medicare Local catchments, ranging from one to three per cent. The range of adults who did not see a medical specialist due to cost across Medicare local catchments, ranged from three to 14 per cent. [21]

3.33 The Consumers Health Forum of Australia (CHF) noted findings from their national survey which found that nearly two-thirds of respondents indicated they had at some point delayed seeing a medical practitioner. Nearly half of the respondents cited cost as a contributing factor.[22]

3.34 The AMA reported that 7.2 per cent of people living outside major cities defer or do not access a GP due to cost.[23]

3.35 The committee received evidence detailing the impact of the proposed $7 co-payment on accessing GP services.

3.36 The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) advised the committee that they have committed to absorb the co-payment because the community they service will be unable to pay. In light of this, it is estimated that VACCHO will lose approximately $250,000 of the $900,000 in

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19 COAG Reform Council, *Healthcare in Australia 2012-13: Five years of performance*, 30 April 2014, p. 51.

20 Australian Bureau of Statistics, 4839.0—*Patient experiences in Australia: summary of findings, 2012–13*, 21 November 2013, http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0 (accessed 15 August 2014).

21 National Health Performance Authority, *Healthy Communities: Australians' experiences with primary health care in 2011-12*, June 2013, p. 5.

22 Mr Adam Stankevicius, *Committee Hansard*, 29 July 2014, p. 1.

23 Australian Medical Association, response to question on notice, 29 July 2014 (received 15 August 2014).

Medicare income they currently receive annually. This reduction will likely result in VACCHO reducing their Aboriginal health worker staff numbers by three.[24]

3.37 Mr Gordon Gregory, Executive Director, National Rural Health Alliance told the committee:

> …based on available data, our estimates are that the introduction of a $7 co-payment would almost double the average annual out-of-pocket costs that Australians pay for GPs. In addition, we anticipate that a $7 co-payment will present a dilemma, especially for lone GPs in small rural and remote towns, and that the viability of these medical practices may be reduced, with consequences for access to health services in those towns. Further consideration of the impact of proposed new co-payments should therefore include their differential impact on people in rural and remote areas. There should be modelling of the effects of such additional payments across remoteness and SEIFA [Socio-Economic Indexes for Areas] gradients, particularly on such things as skipped or delayed visits to GPs and other clinicians and on potentially preventable hospitalisations'.[25]

Access to pharmaceuticals

3.38 Submitters and witnesses expressed concern about the impact of increased co-payments on individuals' access to pharmaceuticals with existing out-of-pocket costs already affecting individuals' adherence to their medication regimes.

3.39 The committee heard a debate over the evidence regarding the extent to which an increased co-payment would impact individuals' decisions to fill prescriptions. While the majority of submitters expressed concern that an increased co-payment would impact on compliance with prescribed medication, the Department presented evidence against this proposition.

3.40 Data from the NHPA indicates that the number of adults who reported that they did not fill a medical prescription due to cost ranged across Medicare Local catchments from 5 per cent to 15 per cent.[26]

3.41 The AMA reported that 12.4 per cent of people living in the most disadvantaged areas delayed or did not fill a prescription due to cost, twice the rate for the least disadvantaged areas.[27]

3.42 Mrs Helen Dowling, Chief Executive Officer, Society of Hospital Pharmacists of Australia (SHPA) noted that she was aware of individual case studies and anecdotal

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24 Mr Jason King, *Committee Hansard*, 3 July 2014, p. 59.

25 Mr Gordon Gregory, *Committee Hansard*, 3 July 2014, p. 24.

26 National Health Performance Authority, *Healthy Communities: Australians' experiences with primary health care in 2011-12*, June 2013, p. 5.

27 Australian Medical Association, response to question on notice, 29 July 2014 (received 5 August 2014).

evidence but that data on what scripts are written and subsequently filled is not collected in Australia.[28]

3.43 A representative from the Department of Health advised that the main source of information on this matter is the ABS patient experience survey which asked questions about whether individuals 'delayed' or 'didn't' fill prescriptions. The Department was of the view that the data gleaned from these questions is limited.[29]

3.44 The last increase to the PBS co-payment occurred on 1 January 2005 when the co-payment increased by 21 per cent. The Consumers Health Forum of Australia provided evidence about the impact of the 2005 increase on individuals:

> Studies have shown that, following the January 2005 increase in PBS copayments, there was a significant decrease in dispensing volumes observed across 12 of the 17 medicine categories, including anti-epileptic medication, anti-Parkinson's treatments, combination asthma medicines, insulin and osteoporosis treatments. Importantly, we also know that the copayment increase had a particular impact at that time on medicine utilisation by concessional patients.[30]

3.45 The Department of Health advised that, although the 2005 changes to PBS co-payments saw the reduction in script volumes in some medications, there was also a significant increase in script volumes in other disease classes. Due to a range of factors, the Department argued that it was inappropriate to draw parallels between the co-payment increase in 2005 and what is currently being proposed.[31]

3.46 During the 2014–15 Budget Estimates, officials from the Department of Health advised that they expect the increased PBS co-payment to result in concession card holders paying, on average, an additional $13.60 per year. This estimated impact has been calculated based on filling 17 prescriptions annually.[32]

Access to dental care

3.47 Evidence provided to the inquiry suggested that out of pocket costs are a key factor in individuals' decisions to visit the dentist.

3.48 Data from the NHPA reported that the percentage of adults who did not see a dental professional due to cost varied across Medicare Local catchments, ranging from 11 per cent to 34 per cent.[33]

3.49 The Australian Dental Association (ADA) provided results from a survey they had undertaken which indicated that 72 per cent of the population see a dentist 'when

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28 Mrs Helen Dowling, *Committee Hansard*, 3 July 2014, p. 12.

29 Mr Richard Bartlett, *Committee Hansard,* 3 July 2014, p. 67.

30 Mr Adam Stankevicius, *Committee Hansard*, 29 July 2014, p. 2.

31 Ms Felicity McNeill, *Committee Hansard*, 29 July 2014, pp 71–72.

32 Ms Felicity McNeill, *Estimates Hansard*, 2 June 2014, p. 45.

33 National Health Performance Authority, *Healthy Communities: Australians' experiences with primary health care in 2011-12*, June 2013, p. 5.

they have a problem' with only 23 per cent reporting a regular visiting pattern. Of the 72 per cent who only attended when there is a problem, 80 per cent had an annual household income of less than $50 000. Further to this, the ADA submitted:

> Cost of care is clearly a factor influencing attendance for care. What remains unclear is whether cost is used as the excuse or whether it demonstrates a failure on behalf of the community to properly prioritise their dental care. Whatever the reason, it is clear that cost is a factor and thus it can be predicted that the likelihood of incurring OOPs [out of pocket costs] will be a reason for non-attendance.[34]

3.50 COTA and National Seniors Australia provided evidence about the high financial burden faced by older people when accessing dental care. Many older people report suffering negative outcomes as a result of poor oral health. The exclusion of dental services from Medicare was a key concern raised by older people.[35]

Impact on different sectors of the community

3.51 Several submitters and witnesses noted that the impact of co-payments is disproportionality felt by vulnerable people across the community. In particular, the committee received evidence about the impact on the Aboriginal and Torres Strait Islander community, people on low and fixed incomes, older people, people with chronic illness and people living in regional, rural and remote communities.[36]

3.52 In their submission, ACOSS referred to the Productivity Commission *Report on Government Services 2014* which noted that it is well documented that people who experience social and economic disadvantage are at risk of negative health outcomes. The Report also noted that higher income and wealth are associated with better health. People with higher incomes are better able to access health services in a timely manner and have greater access to a range of goods and services that have health benefits.[37]

3.53 Carers NSW submitted:

> Carers report that the high costs of health care result in decisions to go without. For some families this may mean going without family leisure, sport and other social activities which promote physical and mental health and wellbeing. For some this may mean making drastic and stressful financial decisions, such as selling the family home.
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> For many families the cost of health care simply means going without health care.[38]

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34 Australian Dental Association, *Submission 57*, pp 7–8.

35 Ms Josephine Root, *Committee Hansard*, 29 July 2014, p. 16; Ms Marie Skinner, *Committee Hansard*, 29 July 2014, p. 17.

36 See for example, Victorian Medicare Action Group, *Submission 39*, p. 1; National Aboriginal Community Controlled Health Organisation, *Submission 42*, p. 3.

37 Australian Council of Social Service, *Submission 61*, p. 7.

38 Carers NSW, *Submission 56*, p. [3].

3.54 The National Aboriginal Community Controlled Health Organisation (NACCHO) noted:

> On average 12 per cent of Aboriginal Australians defer GP visits for more than a year because of costs, more than twice the rate of the general population. Aboriginal Australians also present disproportionately high 'potentially avoidable GP-type presentations' to hospital outpatients particular in major cities and inner regional centres.[39]

3.55 National Seniors Australia reported that older Australians spend $350 per quarter on out-of-pocket health costs. The financial burden is magnified for people with chronic health conditions; people with five or more chronic conditions report spending $882 per quarter on out-of-pocket health costs.[40]

3.56 According to COTA Australia:

> I think it is important to remember that older people come into the three groups that have been identified by other speakers; in fact, they have the triple whammy of being vulnerable because they are older, they are on low incomes on the whole, and they have chronic diseases. So those are the three things that mean that copayments are going to have a negative effect on you, and older people are going to get all three.[41]

3.57 Evidence provided to the inquiry indicated that people living in rural and remote areas are less able to pay out-of-pocket costs, resulting in a greater proportion of people in rural and remote areas postponing or not making visits to a health professional due to the costs.

3.58 GP out-of-pocket health care costs for people in regional areas are 10 to 20 per cent higher in absolute terms than in the major cities, but lower in very remote areas due to the lesser rate at which people have access to a GP. More specifically, the National Rural Health Alliance provided the following evidence to the committee:

- the average amount an Australian pays out-of-pocket for access to a GP is $29.56 a year (averaged across Australia);
- the average out-of-pocket costs for a person who is not bulk-billed is $29.37 per occasion of service. This national average is comprised of: $29.94 in major cities, $27.60 in inner regional, $28.90 in outer regional, $32.59 in remote and $33.82 in very remote.[42]

3.59 The AMA highlighted that the performance of the health system in Tasmania is poorer than in many other jurisdictions. In respect to access to general practice, the AMA stated:

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39 National Aboriginal Community Controlled Health Organisation, *Submission 42*, p. 3.

40 Ms Marie Skinner, *Committee Hansard*, 29 July 2014, p. 17.

41 Ms Josephine Root, *Committee Hansard*, 29 July 2014, p. 16.

42 Mr Gordon Gregory, *Committee Hansard*, 3 July 2014, p. 26.

> Tasmania has a higher burden of chronic disease and higher smoking rates, and we need to do more to encourage preventive health care and chronic disease management. That is why I think the co-payment is probably going to affect Tasmanians more than it affects people in other jurisdictions.[43]

3.60 The Menzies Centre for Health Policy/The George Institute for Global Health provided evidence about the household economic burden of chronic and long-term illnesses, with out-of-pocket costs being a major component. Their submission detailed a study of the experiences of people living with advanced chronic obstructive pulmonary disease. The study reported that 78 per cent of respondents experienced economic hardship from managing their illness and 27 per cent were unable to pay their medical and dental expenses. The economic burden of chronic disease is demonstrated by the evidence that each additional chronic disease adds 46 per cent to the likelihood of a person facing severe financial difficulties due to health costs.[44]

3.61 Several submitters noted that people with chronic illness incur significant out-of-pocket costs due to the complex nature of their conditions and the range of services and medications that may be necessary.

3.62 On this matter, National Seniors Australia advised:

> National Seniors research reveals that overall out-of-pocket expenditure increases steadily as the number of chronic conditions increased. Eighty per cent of 4,500 respondents to a 2009 survey had at least one chronic condition and 56 per cent had more than one condition. The presence and number of chronic conditions increased with age with five or more chronic conditions reported by twice as many (12 per cent) of those aged 75 years and over compared with those aged between 50 and 64 years. Out-of-pocket health expenditure was greatest for medication and medical services with cancer expenditure significantly higher than that for arthritis and high blood pressure.[45]

Impact on health outcomes and costs

3.63 Submitters argued that when medical treatment (such as not visiting a GP when required or filling a prescription) is delayed due to out-of-pocket costs, this will often lead to negative health outcomes.[46]

3.64 As outlined above, several submitters expressed concern that an increase in out-of-pocket costs (for example, in the form of a mandatory co-payment) will impact disproportionally on individuals with the greatest healthcare need, including:

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43 Associate Professor Brian Owler, *Committee Hansard*, 29 July 2014, pp 27–28.

44 The Menzies Centre for Health Policy / The George Institute for Global Health, *Submission 28*, p. 2.

45 National Seniors Australia, *Submission 55*, p. 11.

46 See for example, The Menzies Centre for Health Policy/The George Institute for Global Health, *Submission 28*, p. 3.

Aboriginal and Torres Strait Islanders, elderly people, women, people on low or fixed incomes and people with chronic illnesses.[47]

3.65 Evidence to the inquiry noted that people with chronic illnesses need to access health services on a regular basis. Their capacity to visit GPs and other service providers when required may be affected by the cost of accessing these services. Serious negative health outcomes may occur if regular contact with the necessary health professional is deferred.

3.66 For example, Diabetes Australia submitted information from the latest Report on Government Services that only 25 per cent of Australians met the annual diabetes cycle of care requirements in 2012–13. In particular, many people with diabetes are not having their recommended six monthly check up. Diabetes Australia is concerned that 'having people pay more for health care may worsen access to the recommended cycle of care and the recommended 6 monthly monitoring'.[48]

3.67 Hepatitis NSW expressed concern that an increase in out-of-pocket costs will have a serious and disproportionate impact on communities affected by both hepatitis B and hepatitis C, affecting their ability to pay for healthcare which will result in negative long-term health outcomes.[49]

3.68 National Seniors Australia submitted:

> Respondents to a National Seniors 2009 survey stated that a lack of affordable access to doctors / specialists and health insurance, lack of government support for the health system, long waiting times and general ageing contributed to the deterioration of their health during recent years. People with five or more chronic conditions were significantly more likely to face a moderate (18.6 per cent) or severe (30.5 per cent) financial burden than those with fewer conditions.[50]

3.69 Evidence was also received that if individuals delay treatment, this may result in increased costs to the health system later on as conditions progress and worsen.[51]

Pharmaceuticals

3.70 Evidence provided to the committee noted the negative health outcomes that may arise when individuals do not adhere to their prescribed medication program.

3.71 Mrs Helen Dowling noted that an estimated 50 per cent of patients with chronic diseases are not taking their medications as prescribed. Approximately 10 per cent of patients visiting a GP report having experienced an adverse medication event

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47 See, for example, Royal Australian College of General Practitioners, *Submission 20*, Australian Healthcare and Hospitals Association, *Submission 43*, pp 2–3.

48 Diabetes Australia, *Submission 65*, p. 2.

49 Hepatitis NSW, *Submission 64*, p. 3.

50 National Seniors Australia, *Submission 55*, p. 6.

51 See for example, Chronic Illness Alliance, *Submission 38*, p. 6; National Seniors Australia, *Submission 55*, p. 7.

in the past six months. In relation to emergency department presentations and hospital admissions, approximately two to three per cent of all hospital admissions, 12 per cent of all medical admissions and 20 to 30 per cent of admissions in consumer aged care for patients aged over 65 years are medication related.[52]

Effect of co-payments on other parts of the health system

3.72 The committee notes that the intention of the $7 co-payment on GP visits is to reduce the overall number of GP visits and thereby reduce the Government's contribution to these services.

3.73 Submitters and witnesses emphasised the importance of quality and accessible primary health care services (in particular, GPs). Delivery of quality primary health services is vital not only to respond to individuals' health needs, but to the functioning of the health system as a whole.

3.74 The AMA told the committee:

> Now is not the time to strip money out of primary health care. It is the time to invest in primary care to ensure sustainability of the healthcare system. People need access to general practitioners to know what their healthcare needs are. General practitioners need access to pathology and imaging services in order to diagnose conditions early and put treatment plans in place.[53]

3.75 Evidence to the inquiry explained that primary health care is the most efficient part of the health system. Witnesses emphasised that countries with strong primary healthcare systems report the best health outcomes at the most efficient cost.[54]

3.76 The RACGP observed that there is no economic benefit in dissuading patients from seeing their GP:

> In fact, there is good evidence to suggest that there is a negative economic impact with patients using more expensive health care through the hospital system that could be delivered by general practice at a fraction of the cost. General practice has been, and remains, the most efficient component of the healthcare system, with general practice costs per patient remaining steady over the past 20 years, while hospital costs have continued to rise.[55]

3.77 Evidence to the inquiry indicated that increasing the cost to access a particular section of the healthcare system would affect other services due to the integrated nature of the health system. Submitters and witnesses argued that co-payments may affect other parts of the health system in a number of ways, including by:

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52 Mrs Helen Dowling, *Committee Hansard*, 3 July 2014, p. 10.

53 Associate Professor Brian Owler, *Committee Hansard*, 29 July 2014, p. 22.

54 See for example, Dr Liz Marles, *Committee Hansard*, 3 July 2014, p. 21; Mr Gordon Gregory, *Committee Hansard*, 3 July 2014, p. 24.

55 Dr Liz Marles, *Committee Hansard*, 3 July 2014, p. 15.

- placing increased stress on the public health system (in particular emergency departments) as patients seek hospital treatment to avoid paying a GP co-payment;
- shifting responsibility for primary care to community pharmacies; and
- reducing the number of patients undertaking all required pathology and diagnostic testing.[56]

3.78 In the following section, the effect of co-payments on the following sectors of the health system will be explored in more detail:

- the hospital system;
- pharmacies; and
- bulk-billing rates.

Effect on the hospital system

3.79 Submitters noted that increasing GP co-payments would place increased stress on the public hospital system, especially emergency departments, as patients seek hospital treatment to avoid the co-payment costs associated with GP visits.

3.80 According to Catholic Health Australia:

> High out-of-pocket charges imposed in an uncoordinated way are more than likely already resulting in people receiving care in settings that may not be the most effective or cost-effective. There is evidence that some, many of who have no choice, seek to minimise costs by avoiding or delaying seeking health services, or choosing a provider with lower costs by utilising a hospital emergency department rather than attending a GP who charges out-of-pocket costs.[57]

3.81 The Grattan Institute acknowledged that there is little evidence for whether people are more likely to go to a hospital emergency department if they face higher co-payments at the GP, but that it seems likely. It was suggested that any shift of patients from GPs to emergency departments will increase costs to government because the Medicare rebate for the most common type of GP consultation, which lasts up to 20 minutes, is $36.30. The average cost of a non-admitted level 5 triage visit to a hospital—a likely substitute for a GP visit—is $290.[58]

3.82 Evidence provided to the inquiry indicated that the cost of providing healthcare in a hospital is significantly higher than providing care in a primary health setting. For example, the Australian Healthcare & Hospitals Association referenced a

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56 The impact on other areas of the health system was discussed in a number of submissions. See for example, Australian Women's Health Network, *Submission 36*, p. 5.

57 Catholic Health Australia, *Submission 63*, p. 5.

58 Grattan Institute, *Submission 79*, p. 13.

Northern Territory study which found that costs associated with in-patient care for renal conditions were significantly higher than community based care.[59]

3.83 Taking a similar view, the Doctors Reform Society submitted that although 'studies are lacking, common sense indicates that patients who struggle to afford visits to GPs will consider attending Emergency Departments'. Further to this, it was noted that emergency departments are not designed to deal with many of the problems dealt with by GPs.[60]

3.84 The National Rural Health Alliance (NRHA) noted that one of the impacts of missing out on primary care is a higher rate of avoidable hospitalisation. Further to this, using data from the NHPA, the NRHA submitted:

> The age-standardised rate of potentially avoidable hospitalisations increases significantly with remoteness. For example, in 2011–12 the age-standardised rate of potentially avoidable acute and vaccine-preventable conditions ranged from 1,135 hospitalisations per 100,000 people in Inner West Sydney to 3,125 per 100,000 people in Central and North West Queensland.[61]

3.85 The importance of primary health care being delivered by GPs and not in emergency departments was also raised in submissions. The Australian College of Nurse Practitioners observed:

> Specifically, patients who either cannot afford or who wish to avoid the co-payment will use the ED [emergency department], as their first point of contact, for their healthcare. The focus for EDs is to manage emergent and episodic care, and patients see a different clinician every time they present. If a patient uses ED for primary care services the continuity and ongoing management of their primary healthcare conditions will become fragmented.[62]

3.86 Dr Stephen Duckett, Director, Health Program, Grattan Institute outlined the difficulties to quantify the impact of possible redirection of GP visits to emergency departments. Dr Duckett suggested that if one in five of the estimated one million GP services that will not occur as a result of the new co-payment presents to an emergency department, there will be no savings to total government expenditure.[63]

Co-payment charges in hospitals

3.87 The committee notes recent speculation that hospital emergency departments will be encouraged to charge a co-payment to reduce the possibility that individuals will present to emergency departments to avoid paying the GP co-payment. A number of witnesses questioned the appropriateness and practicality of this proposal. The

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59 Mr Andrew McAuliffe, *Committee Hansard*, 29 July 2014, p. 10.

60 Doctors Reform Society, *Submission 26*, p. 3.

61 National Rural Health Alliance, *Submission 54*, p. 13.

62 Australian College of Nurse Practitioners, *Submission 70*, p. 6.

63 Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, p. 34.

Australian Healthcare & Hospitals Association suggested that idea is impractical because additional staff and infrastructure would be required to manage billing procedures.[64]

3.88 The Department of Health advised that the introduction of patient contributions for GP-type patients in public hospitals is a matter for states and territories. The Department also noted that:

> …public hospitals already collect payments for non-Medicare eligible patients presenting for treatment in Emergency Departments. Therefore, states show existing capability to levy patient contributions for certain types of patients.[65]

Effect on pharmacies

3.89 Evidence provided to the inquiry suggested that the introduction of a GP co-payment may shift greater responsibility of primary care to community pharmacies.

3.90 The Pharmacy Guild of Australia submitted that pharmacies already provide a range of services and advice for minor health conditions and expressed caution about the increased pressure that may be placed on these services should a GP co-payment be introduced.[66]

Effect on bulk billing

3.91 The committee heard evidence that the introduction of the $7 co-payment will impact on the capacity of GPs to bulk-bill due to the increased financial burden it will place on their practice.

3.92 Under the proposal, all patients will be required to pay $7 towards the cost of GP consultations. For concession card holders, the $7 contribution will be capped at 10 visits per calendar year for GP, out-of-hospital pathology and diagnostic imaging services. If a GP decides not to charge the $7 co-payment on existing bulk-billed services, they will receive the revised Medicare rebate of $31.30. If the GP was to charge the $7 co-payment, they would receive between $38.30 and $47.40 depending on the patients' concessional status and the level of low gap incentive payment applied.[67]

3.93 The Australian Medical Association stated:

> I think the fundamental question here is really whether it is feasible for a medical practitioner to bulk bill in those circumstances. The problem that we have is that there is a cut to the Medicare rebate. For non-concession patients the $5 cut to the rebate means that, if they do not charge the co-

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64 Australian Healthcare & Hospitals Association, *Submission 43a*, p. 2.

65 Department of Health, answer to question on notice, 29 July 2014 (received 6 August 2014).

66 Pharmacy Guild of Australia, *Submission 41*, p.13.

67 Department of Health, *Strengthening Medicare*, June 2014, p. 1, http://www.health.gov.au/internet/budget/publishing.nsf/content/budget2014-factsheet-strengthening-medicare (accessed 7 August 2014).

> payment, the doctor will be $5 worse off. That is out of a $36 co-payment to start with. For patients who are under a concession who would under this plan receive what is called the low-gap incentive, not only would they lose the $7 co-payments but they would also lose the low-gap incentive. For patients in metropolitan areas, I understand that then adds up to $13. For patients who are in regional areas, of course, there is a $9 low-gap incentive, so it is an extra $3, or $16.[68]

3.94 Dr Duckett noted that in proposing the GP co-payment, the Government has created a significant financial disincentive for doctors who wish to bulk-bill. The current bulk-billing incentive will be replaced with a low-fee incentive. Dr Duckett suggested that, under the proposed new arrangements, if a doctor bulk-bills, they will be approximately 30 per cent worse off than they would otherwise be.[69]

3.95 Dr Liz Marles, President, RACGP explained that GPs will receive financial incentives to charge the co-payment:

> …so you will actually get a low gap incentive if you charge the co-payment. If I charge that $7, I will get a bonus $6 or $9, whereas if I bulk-bill them that money is not there. We are being positively incentivised to charge the co-payment to all patients whether they are concession card holders or not, and that will translate into increased costs.[70]

3.96 Officials from the Department of Health emphasised that it will be up to individual GPs to decide how best to apply the co-payment to suit the needs of their practice. It was acknowledged that, as is the case under the existing system, GPs will approach the situation differently and with the necessary business decisions to reflect their practice.[71]

Safety nets and other offsets

Introduction

3.97 There are two safety nets in the Australian healthcare system—the Medicare Safety Net and the PBS Safety Net. The safety nets provide assistance to individuals and families by reducing out-of-pocket costs once their Medicare or pharmaceutical expenses have exceeded the applicable threshold amount.

3.98 This section will commence with discussing the evidence received about safety nets generally and then discuss particular issues arising in relation to either the Medicare safety net or the PBS safety net.

3.99 The 2014 Medicare Safety Net thresholds are shown in the following table:

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68 Associate Professor Brian Owler, *Committee Hansard*, 29 July 2014, p. 22.

69 Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, p. 31.

70 Dr Liz Marles, *Committee Hansard*, 3 July 2014, pp 20–21.

71 Mr Richard Bartlett, *Committee Hansard*, 29 July 2014, p. 65.

Table 3.1: 2014 Medicare Safety Net thresholds

	Threshold amount	Who it is for	How it is calculated	What the benefit is
Original	$430.90	All Medicare cardholders	Based on gap amount	100% of schedule fee for out of hospital services
Extended Concessional and FTB Part A	$624.10	Concession cardholders and families eligible for FTB Part A	Out of pocket costs	80% of out of pocket costs or the EMSN benefit cap for out of hospital services
Extended general	$1,248.70	All Medicare cardholders	Out of pocket costs	80% of out of pocket costs or the EMSN benefit cap for out of hospital services

Source: Department of Human Services, *2014 Medicare Safety Net thresholds*, http://www.humanservices.gov.au/customer/enablers/medicare/medicare-safety-net/medicare-safety-net-thresholds (accessed 15 August 2014).

3.100 From 1 January 2015, the threshold for the Extended Medicare Safety Net will be increased to $2 000.

3.101 In the 2014–15 Budget, the Government announced that from 1 January 2016 a Single Medicare Safety Net (SMSN) for out-of-hospital services will replace the Extended Medicare Safety Net (EMSN), the Original Medicare Safety Net and the Greatest Permissible Gap. The SMSN will have three thresholds:

- $400—for singles with a concession card or families with a concession card;
- $700—for singles with no concession card or families receiving Family Tax Benefits Part A with no concession card; and
- $1000—for families with no concession card.[72]

3.102 From 1 January 2016 there will be a limit on the out-of-pocket costs that count towards reaching the threshold. There will also be a maximum Medicare Safety Net benefit paid per service, which is based on the Medicare Benefits Schedule Fee for the service.[73]

3.103 The 2014 threshold for the Pharmaceutical Benefits Scheme Safety Net is $1 421 for general patients and $360 for concession card holders. General patient contribution per prescription is up to $36.90 and $6 for concession card holders. Once the threshold is reached, the cost for prescriptions is $6 for general patients and no charge for concession card holders.

72 Department of Human Services, *Budget 2014-15: Simplifying Medicare safety net arrangements*, May 2014, http://www.humanservices.gov.au/corporate/publications-and-resources/budget/1415/measures/health-matters-and-health-professionals/29-000490 (accessed 28 June 2014).

73 Department of Health, answer to question on notice, 29 July 2014 (received 6 August 2014).

3.104 In the 2014–15 Budget, the Government announced changes to the PBS safety net to commence on 1 January 2015 estimating the following changes:

- general patient contribution of $42.70 and $6.90 contribution once the revised threshold of $1597.80 is reached.
- concession card holder contribution of $6.90 and no charge once the revised threshold of $427.80 is reached.[74][75]

3.105 According to the Department of Health:

> The extended Medicare safety net has undergone significant change to ensure that it is more focused on supporting patients and less supportive of medical inflation. This will culminate in the safety net announced in the budget which will support more people than the current arrangements, albeit with lower benefits.[76]

Appropriateness of current safety nets and other offsets

3.106 Submissions to the inquiry indicated that existing safety nets do not benefit or assist people who are most in need of support from a safety net. In particular, attention was drawn to the challenges faced by people on low incomes and with chronic illnesses who experience disadvantage in accessing healthcare due to out-of-pocket costs.

3.107 Issues impacting an individuals' ability to access and benefit from existing safety nets include:

(a) the high out-of-pocket costs incurred before reaching the threshold amounts;

(b) complexity of the safety net system; and

(c) the health expenditure that does not contribute to the safety net threshold amounts.

3.108 The committee heard evidence from Professor Stephen Jan, The George Institute for Global Health who noted that the current safety net limits the annual out-of-pocket expenses of Medicare-reimbursed services. Professor Jan explained that the limitation of the safety net is that there is still a significant financial burden as individuals must pay for services until they reach the safety net threshold. This financial burden acts as a deterrent to accessing healthcare. It should also be noted that

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74 Department of Health, *2014 Budget information on the Pharmaceutical Benefits Scheme,* 13 May 2014, http://www.pbs.gov.au/info/news/2014/05/2014-budget-information (accessed 28 June 2014).

75 On 19 June 2014, the Selection of Bills Committee referred the provisions of the National Health Amendment (Pharmaceutical Benefits) Bill 2014 to the Community Affairs Legislation Committee for inquiry and report by 26 August 2014. This bill would give effect to the changes announced in the Budget.

76 Mr Richard Bartlett, *Committee Hansard*, 3 July 2014, p. 64.

there are many out-of-pocket costs that are incurred outside of Medicare services and therefore do not contribute to the safety net.[77]

Medicare safety net

3.109 Out-of-pocket medical expenses that contribute to the Medicare Safety Net are automatically monitored by Medicare although the process for monitoring payments differs slightly depending on individuals' method of paying for medical services. Once the relevant threshold is reached, a higher Medicare rebate may be provided for all eligible for the rest of the calendar year.

3.110 Evidence provided to the inquiry suggested that the eligibility criteria to qualify for the EMSN should be reviewed to better target people who have insufficient means to pay for health services.

3.111 The Tasmanian Council of Social Service submitted:

> It is evident, however, that the Safety Net does not currently benefit people on low incomes, despite its intention to do so. The figures in the 2009 review of the EMSN disturbingly showed that 55% of EMSN benefits had been distributed to the top quintile of Australia's most socioeconomically advantaged areas, and that the bottom quintile received less than 3.5%. This is an enormous disparity, and means that ultimately the EMSN might be simply "helping wealthier people to afford even more high-cost services".[78]

3.112 Submitters did not support the EMSN threshold being increased to $2 000. For example, National Seniors Australia submitted that the increase 'is inequitable and hurts people who are living with chronic health conditions'.[79] The committee notes that the EMSN will come into effect on 1 January 2015 for a period of 12 months when it will be replaced by the Simplified Medicare Safety Net.

3.113 National Seniors Australia and Consumers Health Forum observed that the Simplified Medicare Safety Net as proposed has various exclusions and caveats that are very difficult for individuals to understand.[80]

3.114 The Department of Health estimated that 770 000 individuals will receive Medicare Safety Net benefits in 2015 and, following the commencement of the Extended Medicare Safety Net in 2016, an estimated 830 000 individuals will receive benefits.[81]

Pharmaceutical Benefits Scheme safety net

3.115 In contrast to the process required to qualify for the Medicare safety net, to qualify for the PBS safety net, individuals (or pharmacists on the individual's behalf)

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77 Professor Stephen Jan, *Committee Hansard*, 3 July 2014, p. 2.

78 Tasmanian Council of Social Service, *Submission 67*, p. 5.

79 National Seniors Australia, *Submission 55*, p. 13.

80 Mr Adam Stankevicius, *Committee Hansard*, 29 July 2014, p. 3; Ms Marie Skinner, *Committee Hansard*, 29 July 2014, pp 18–19.

81 Department of Health, answer to question on notice, 29 July 2014, (received 6 August 2014).

must keep a record of all PBS medicines on a Prescription Record Form. Once the safety net threshold is reached, a PBS Safety Net card is issued which ensures access to cheaper or free PBS medicines for the rest of the calendar year.[82]

3.116 Several submitters expressed concern at the additional record keeping requirements for individuals (or pharmacists on the individual's behalf) wishing to access the PBS safety net. It was noted that many people may be missing out on the intended benefits of this safety net.[83]

3.117 The committee is aware that in the 2013 calendar year, there were 119 463 PBS Safety Net cards issued for general patients, noting that these cards may apply to an individual, a couple or a family. The 119 463 cards covered 236 942 patients.[84]

3.118 The current PBS safety net for concession patients is set at the equivalent of 60 PBS prescriptions per year at the concessional rate. During the 2014–15 Budget Estimates, officials from the Department of Health provided evidence about the changes under the new safety net from 1 January 2015:

> So, if I look to what the changes will be in January 2015, the general safety net will increase by approximately $145.30, from $1,452.50 to $1,597.80; and the concessional safety net will go from 60 scripts to 62. In 2016, we expect that the general safety net will then be increased to $1,798; in 2017, we expect it to be at $2,029.20; and, in 2018, we expect it to be at $2,287.90. For the concessional safety net, it will go up to 64 scripts in 2016, 66 scripts in 2017 and 68 scripts in 2018. I would like to just put one caveat on all of that, which is that the calculation of the safety net is reliant on the CPI figure for the September quarter on a 12-month average, and therefore these are very much approximates because they are completely dependent on what the final CPI figure would be in each year.[85]

3.119 Submitters also described challenges experienced by people on low incomes to pay for prescriptions before they have reached the safety net threshold. In addition, particular attention was drawn to the experience of individuals with chronic illnesses who may be purchasing multiples prescriptions and incurring high out-of-pocket costs.

3.120 The Healthcare Consumers Association ACT suggested that individuals with lifelong conditions should be able to pay the discounted safety net price immediately rather than incurring out-of-pocket costs to meet the respective threshold.[86]

3.121 Professor Jan noted that even though the safety net is in place, the PBS costs that people face, particularly individuals with conditions that require multiple

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82 Department of Human Services, *Pharmaceutical Benefits Scheme Safety Net*, http://www.humanservices.gov.au/customer/services/medicare/pbs-safety-net (accessed 22 July 2014).

83 See for example, Queensland Aboriginal and Islander Health Council, *Submission 58*, p. 6.

84 Ms Felicity McNeill, *Estimates Hansard*, 2 June 2014, p. 46.

85 Ms Felicity McNeill, *Estimates Hansard*, 2 June 2014, p. 46.

86 Healthcare Consumers' Association ACT, *Submission 66*, p. 18.

medications, still act as a significant barrier to people using their prescribed medications which can lead to non-adherence and then further costs at a later time.[87]

3.122 Mrs Helen Dowling, Chief Executive Officer, Society of Hospital Pharmacists of Australia advised the committee that, based on the Department of Health's PBS budget information, in four years:

> Just to highlight the significance of this, in four years the co-payment today for each category will rise from the current general non-concessional rate threshold of $1,421.20 to $2,287.90 in 2018. That is a 61 per cent increase in the threshold. For the concessional rate today, this equates to $360 for 60 prescriptions at $6 each to $510 in 2018 for 68 scrips. That is a 24 per cent increase, as highlighted. We are concerned that this will make it almost impossible for an average family to reach the safety net threshold, especially if the number of prescriptions needed to reach this threshold also increases, as is stated, from 60 to 68 over the same four years.[88]

3.123 On the matter of the number of filled prescriptions required to reach the safety net threshold, Mrs Dowling advised that:

> Today this represents 38 script items at a price of $36.90; in 2018 if the script fee is increased at the same rate as the threshold, then the number of scripts would be anticipated to be the same for general patients.[89]

Other offsets

3.124 In addition to the two safety nets, other measures such as health care cards and the medical expenses tax offset are available to provide some reduction in out-of-pocket health costs. Individuals with health care concession cards are eligible to no or low cost medical treatment and prescriptions. Safety net thresholds are significantly lower for health care card holders.

3.125 The net medical expenses tax offset allowed individuals to claim 20 per cent of the amount of net medical expenses (total medical expenses minus Medicare and private health insurance rebates) above $2 060 as a deductible expense. Commencing in July 2013, the net medical expenses tax offset will be phased out. To be eligible to claim in 2014–15, individuals must have received the offset in their 2013–14 income tax assessment. 2014–15 is the final year patients can claim the tax offset unless they have medical expenses relating to disability aids, attendant care or aged care, in which case the tax offset can be claimed for these items up to the 2018–19 income tax year.[90]

3.126 The Healthcare Consumers' Association ACT noted consumers concerns about tax offsets and the use of healthcare cards for those whose partners and/or carers

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87 Professor Stephen Jan, *Committee Hansard*, 3 July 2014, p. 3.

88 Mrs Helen Dowling, *Committee Hansard*, 3 July 2014, p. 11.

89 Society of Hospital Pharmacists of Australia, answer to question on notice, 3 July 2014 (received 3 July 2014).

90 Australian Taxation Office, *Medical expenses*, 22 July 2014, https://www.ato.gov.au/Individuals/Income-and-deductions/Offsets-you-can-claim/Medical-expenses/ (accessed 13 August 2014).

earn just above, or above the threshold. It was observed that many consumers stated that managing chronic conditions without a health care card meant high costs for pharmaceuticals and medical supplies.[91]

3.127 Evidence received from the Breast Cancer Network Australia expressed disappointment that, following the 2013–14 Budget, the net medical expenses tax offset is being phased out. It was noted that the offset provided some respite to Australians with high medical costs, including those living with cancer.[92]

Recommended changes to the safety nets

3.128 Several witnesses advocated for changes to the Medicare and PBS Safety Nets. While there was some discussion about the optimal level of the safety net threshold, the majority of evidence provided to the inquiry argued for more structural changes to the safety net and transition to a more simplified and integrated approach.[93]

3.129 Submitters and witnesses noted the importance of ensuring that the safety net is patient focused and facilitates improved health outcomes.

3.130 Mr Patrick Tobin, Director, Policy, Catholic Health Australia told the committee that the safety net needs to be designed around the consumer:

> At the moment, the safety nets have been designed by different parts of our siloed system and so, as well as being difficult to understand, if people have to separately qualify for different aspects of a particular safety net then that just makes it much harder.[94]

3.131 The Consumers Health Forum argued that safety nets should be more integrated and encompass a range of health services:

> One of the biggest issues we have is that, at the moment, safety nets are designed to address one-off, acute interactions with the healthcare system, so it is annual expenditure. But we are seeing the burden of disease shift to more chronic disease management, so it is ongoing expenditure. For consumers to have to deal with the Medicare safety net only after the expenditure has been incurred puts a heavy burden on people, especially those with conditions like asthma and diabetes, who need the assistance as and when it occurs.[95]

3.132 Carers Queensland recommended the implementation of a robust safety net which is clearly defined and crosses all forms of treatment.[96] This approach was supported by several submitters and witnesses. Evidence suggested that the Medicare

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91 Healthcare Consumers' Association ACT, *Submission 66*, p. 18.

92 Breast Cancer Network Australia, *Submission 51*, p. 9.

93 See for example, Mr Andrew McAuliffe, *Committee Hansard*, 29 July 2014, p. 13; Ms Josephine Root, *Committee Hansard*, 29 July 2014, p. 18.

94 Mr Patrick Tobin, *Committee Hansard*, 29 July 2014, p. 13.

95 Ms Priyanka Rai, *Committee Hansard*, 29 July 2014, p. 3.

96 Ms Sarah Walbank, *Committee Hansard*, 3 July 2014, p. 53.

Safety Net should be looked at more holistically to include allied health services such as occupational therapy, physiotherapy and healthcare provided by nurse practitioners.[97] This holistic approach to patient care will likely become more important as the population ages and the number of people with multiple conditions increases, placing increasing pressure on the healthcare system.

Committee view

3.133 The committee notes that the purpose of a co-payment is to create a price signal for consumers as a means of reducing unnecessary visits to general practitioners and the use of pathology and diagnostic services.

3.134 Evidence provided to the inquiry suggested that there was limited evidence to suggest there is over-servicing in primary healthcare. In fact, there is evidence to suggest that in some areas and communities there is significant under-servicing.

3.135 The current level of out-of-pocket costs in healthcare is already impacting on an individuals' access to healthcare. The available data indicates that many Australians are delaying visits to their GP and dental service or not filling all of their required prescriptions. The committee heard evidence that the impact of co-payments is disproportionality felt by vulnerable people across the community.

3.136 The committee is concerned that imposing an additional co-payment will make it even harder for individuals, particularly vulnerable groups, to access primary health care.

3.137 Deferring seeking medical treatment may impact not only on an individuals' health but may also affect other parts of the health system whereby primary health visits are redirected into the public hospital system.

3.138 The committee is concerned that existing safety nets do not benefit or assist people who are most in need of support from a safety net. Often individuals will incur significant out-of-pocket costs before they reach the respective threshold amount. As outlined throughout the inquiry, out-of-pocket costs can be barriers to access healthcare.

3.139 The committee notes that the safety nets are complex and many people report difficulty understanding the requirements and thresholds that must be met to qualify. This is particularly relevant for the PBS Safety Net as individuals are required to keep their own record of prescription medications. In this situation, there is a risk that people will not maintain the correct records and fail to qualify for the safety net.

3.140 The committee notes that the health costs that may contribute towards the safety net are limited. The committee believes a single, integrated safety net should be developed but notes that careful consideration would need to be given to what services and costs are eligible to contribute to the safety net.

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97 See for example, Australian Physiotherapy Association, *Submission 22*, p. [4–5].