Submission the Senate Select Committee on Out of Pocket Expenses

prepared by Prof Peter Brooks AM MD FRACP FAFPHM FAFRM

Senators - I submit the following information to your Committee of Enquiry and hope it will assist you in your deliberations on what I think is one of the fundamental issues influencing our health care system now and into the future – how we as a nation pay for what is one of the better health systems around but one that could be so much better and so much more productive if only we took notice of evidence – both from here and overseas

Why do I make this submission

– I have been a clinician , researcher ,health and education administrator for over 50 years and feel passionately about the health system and about equity and access to it . When I was Executive Dean of Health Sciences at the University of Queensland (1997-2009) I developed a major interest in how we might better organise our health system and in particular how we might make our health workforce more productive . I established the Australian Health Workforce Institute at the University of Melbourne which is now part of the Centre for Health Policy in the School of Population and Global Health . I also work 2 days a week as the Exec Director Research at Northern Health Epping – on the outskirts of Melbourne – serving what is one of the most rapidly growing and culturally diverse areas in Australia – an area with a significant number of 'at risk '(health wise) people .

I believe the questions you need to address are issues such as

- What exactly are out of pocket expenses (OOPexps)
- Who determines them and on what basis
- Should they be levied and by / to whom
- How do they influence use of the health system
- Are they impacting on other parts of the health system – for example influencing whether medical students opt to pursue a career in General Practice or go into Specialist Practice
- What is experience with OOPexps in overseas environments and its impact on health service costs

You owe it to all Australians to look at some of the data that are available and make your judgment as to what is the best way of tackling this important issue based on that evidence – and where there is no or conflicting evidence suggest ways by which that evidence might be obtained . Having made determinations on OOPexps it will be important for you to ensure that some evaluation process is established to follow the results of your recommendations . In that way you will do a great service to all Australians not just now but into the future .

Out of Pocket Expenses

What are they/ how are they determined / how are they levied

Out of pocket expenses (in Health)are those expenses not covered by Medicare or by some other form of private insurance . They make up in excess of $22 billion per annum and are one of the most rapidly growing parts of the health budget (Stephen Jan, Beverley M Essue and Stephen R Leeder (Med J Aust 2012; 196 (1): 29-31.).

How they are arrived at is not clear – they seem to vary significantly across the system some doctors charging small OOPexps – others large with no clear basis .One might ask this of the various fee setting bodies that seem to operate across the health care system in Australia . Medicare has a fee setting body which reviews the Medicare fee schedule on a regular basis . The Australian Medical Association also sets a fee (higher) for Medicare item numbers – presumably it has a basis for this but it is not transparent . Individual doctors then set their own fees and it is this and the AMA fee schedule which produces the problem of OOPexps . These fees are levied on the most vulnerable in our society – those who are unwell and require medical attention – whether it is for treatment or prevention . These patients should surely be entitled to know what they are paying for and how that sum has been determined . As we move towards a health system that is (should be) patient focused and requiring of greater patient participation in health decision making then it surely is only logical to present these fees in a transparent fashion .

Doctors are supposed (required) to discuss any OOPexps with a patient prior to the procedure . This is not always done and if so often by the nurse or receptionist or by notice in the waiting room (for consultations) . Patients often do not appreciate this as they are in a stress full state visiting their doctor and concerned about their health .
The thought that one can have any debate about OOPexps in this situation beggars belief . Imagine that you have been told by a surgeon that the operation next week is going to cost $4000.00 out of pocket – are you (the patient) really going to question this – and do you have any idea of what the 'benchmark 'OOPexp for this procedure is , when that surgeon is going to open your abdomen or head next week ! It is too silly to even contemplate. There really should be an open disclosure about these fees and if they cannot be justified then they should not be levied . Other countries such as Canada – which has a similar type of health system to ours does NOT allow doctors to charge in excess of the government rebate . In the US fees are continually being reduced by the large insurance companies (Kaiser Permenante etc) and as an exemplar – you may note that the cost of cataract surgery – now a 15 minute procedure – has dropped by 34% since 2000 and is 85% less expensive than in 1985 (Brown et al Cataract Surgery Cost Utility Revisited in 2012 . http://dx.doi.ord/10.1016/j.ophtha.2013.04.030) .Ehy is it so different in Australia. What is also interesting about US doctors (and not well appreciated by Australians) is that there are now more doctors in the US on salaries (greater that 50% of doctors)than on fee for service and this number is increasing every year . You may say what has this all got to do with OOPexps – well it provides an international perspective on the issue of how medical expenses are levied and on what are a major determinant of health care costs .

OOPexps as a determinant of Doctor renumeration

There is no data available that I am aware of on the breakdown of Medicare renumeration / OOPexps or other fees in their renumeration ' package '. What can be said is that doctor salaries in

Australia are at the higher end of the international scale and certainly at the top end of Australian salaries . The OECD Report Health 2013 reports that general practitioners in Australia earn about 1.6 times the OECD average while specialists earn around 5 times the OECD average .

http://www.google.co.uk/url?sa=t&rct=j&q=oecd%20health%20data%202013%20australia&source=web&cd=1&cad=rja&uact=8&ved=0CC4QFjAA&url=http%3A%2F%2Fwww.oecd.org%2Fels%2Fhealth-systems%2FBriefing-Note-AUSTRALIA-2013.pdf&ei=jKFoU_LFOsaX0QWcq4GwAQ&usg=AFQjCNGh1FCpg0lKfLmWxfxCoa03tTzCzA&bvm=bv.66111022,d.d2k

Now this has a number of important aspects

- Firstly we are at a stage in our demography where we have an ageing community and one where many of us suffer chronic diseases . There is reasonable evidence that a generalist (general physician or general practitioner are much better placed to provide care for this increasing segment of the population and in fact studies have shown better health outcomes achieved by generalists. So we need Generalists – yet renumerate them poorly

- Second – we sing the benefits of our universal health care system internationally and emphasise how it is based on general practitioners as the key 'gate keepers ' and coordinators of care and yet we pay them at a third of the rate of specialists (OECD HEALTH 2013 and Scott http://www.racgp.org.au/afp/2014/april/does-remuneration-matter/ . This issue of total renumeration is important in that OOPexps area major way in which doctors can increase their incomes and that the ability to do so is far greater for a specialist than for a GP given the higher base fees and the fact that they (specialists) are engaged in more procedural work which is itself renumerated at a much higher rate than non procedural work .
- There is some data supporting the fact that medical students are influenced by income when they make career choices at the end of Medical School – again Scott has shown that a $50000.00 increase in salary for GPs (20%) would result in an increase of 10 % - moving from 40% to m50% of graduating medicals students choosing career in general practice . This could make a major difference in our ability to attract some of those GPs to work in underserved and rural areas While this issue will not be directly influenced by reducing OOPexps it will influence the differential in renumeration between GPs and Specialists which contributes to the current imbalance of carer choices in medicine.
- According to the OECD report Australia has the second widest gap between generalist and specialist renumeration – just behind Belgium . As a rheumatologist my overseas colleagues can never understand why I would earn a fraction of an orthopaedic surgeons salary- this just does not happen in Canada , in Europe or UK . Removing the ability to charge OOPexps would address this imbalance to some extent

What is the effect of OOPexps on patient 'compliance' with seeking health **advice**

There is increasing anecdotal and published data to support the contention that OOPexps (and any other copayment) is becoming a significant factor in stopping patients from seeking medical advice and not filling prescriptions . Patients with chronic disease – who are required to see a doctor for repeat prescriptions and for regular review will not be able to use GPs or specialists who charge an OOPexp .- and will swell the public hospital outpatients or just not get preventive health advice which may prevent an expensive hospitalisation or an exacerbation or complication of their illness

with a significant increase in costs – loss of ability to work , need for other community supports etc . The effects of the increasing OOPexps . on downstream health and social care need to be factored in to any consideration and these costs will be bourne significantly more by the most vulnerable in the community – the elderly , the chronically diseased and those unemployed and in other at risk groups

Finally there is the issue of maintaining private health insurance itself – at what stage will individuals consider giving up private health insurance because it does not cover the OOPexps . There must surely be a point when individuals / families will reconsider their options in relation to private health insurance because the amount covered becomes less and less as the OOPExps rapidly increase as they have in recent years

Could the level of OOPexps charged lead to overservicing or continuing use of interventions (surgeries , investigations and therapies) that have little or no proven benefit (and may cause harm)- so called 'low value ' health care practices :

Now this is always a difficult issue but there is increasing evidence from researchers and clinicians in Australia and overseas that a significant output of the health system adds little or no benefit to patient care . It has been estimated that upwards of 20% of procedures / investigations carried out in US and Australia do little to enhance the patients well being (Elshaugh et al

Over 150 potentially *low-value* health *care* practices: an ...

*www.ncbi.nlm.nih.gov/pub**med**/23163685*

, Scott et alLooking for *value* in health *care* | *Medical Journal* of *Australia*

*https://www.mja.com.**au/journal**/2012/197/10/looking-**value**-health-**care***

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Avoiding *Low-Value Care* — NEJM

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www.nejm.org/doi/full/10.1056/NEJMp1401245

Better *U.S. Health Care* at *Lower* Cost | Issues in Science ...

issues.org/26-2/milstein/

If we were to address these issues of low value care and not fund them then this alone would deliver some $20 billion not just as one off , BUT every year ,in health care savings which could be used to carry out care that does work !

What may you ask has this to do with OOPexps – well if this is so and OOPexps are being charged widely across the system then a significant number of patients are being charged an OOPexp for something that does not provide any health benefit and in fact may cause some harm.

One might consider the following scenario

- It is one thing to charge an OOPexp for a procedure
- Another to charge an OOPexp for something that is of questionable benefit to the patient (Low value procedure)
- And surely something else to charge an OOPexp for a low value procedure that is associated with an adverse event

I have tried to outline some of the issues you will need to consider in your deliberations . You have a big task –and OOPexps are but one factor in the rapidly rising cost of health care but one that could be tackled with some 'brave ' decisions 'in the interests of patients .
OOPexps are complex , unjustified and impact negatively on the health of the nation .

If they are not curbed then it behoves all payers of health care costs which included patients / community , private health insurers , private hospitals, governments and the health professions themselves to look at ways of acting individually and /or in concert to prevent OOPexps being levied . This might involve health insurers setting fees for certain procedures and informing patients of doctors who are registered providers of services as happens in the US and is developing here , private hospitals / community services not accrediting doctors who charge excessively , the health professions – particularly the Colleges – taking a firm stand on the issue and last but not least patients (and particularly groups such as the Consumer Health Forum) using social media websites to .provide information on health professionals and their charging practices .
We are entering an exciting era of health care where patients can and will be engaged at a much greater level in their own health care- and this will include what they are paying for that advice . The health profession need to be part of the solution and not remain a part of the problem

I enclose an article I wrote recently about my own experiences and anecdotal reports (from colleagues)include OOPexps of up to $25 ooo.oo for a prostatectomy (say 3 hours work and some follow up visits) and $43ooo.oo for a complex fusion of the spine . For cataract surgery my N of around 10 (that is colleagues having cataract surgery) is around two to three thousand dollars per eye – not bad for about 15 minutes work I am sure you will agree !

Now the argument I have heard from practitioner is that the Medicare fee just does not cover the expenses that are required – equipment / staff wise . If this so then perhaps a more rational approach would be to look at those costs from a proper business perspective – I suspect there would be significant exigencies of scale leasing rather than buying equipment etc perhaps even asking if the latest gadgetry really does produce the added clinical benefit that justifies the extra cost . It also raises the issue as to whether the intervention should be embarked on in the first place .

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Out of pocket expenses getting out of hand

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OUT of pocket expenses (OPEs) for health is becoming a significant issue for many Australians and now makes up over $20 billion of the health budget.

Surely it's time to look carefully at what they are supposed to cover — who generates them and how are they justified?

This seems to be an issue that is shrouded in mystery. Although doctors are expected to discuss these fees with a patient, it seems often left to the receptionist or nurse to have this conversation and then it is really just for information — do we really think a patient is going to refuse to pay or have a discussion about the fee when we are operating on them tomorrow?

I recently had my triennial oesophagoscopy and was told I would have to pay $150 before the booking could even be made, and I gather this is not an unusual process. This is not the profession I went into 45 years ago! Should we go on condoning this behaviour among our colleagues or should we start saying this has gone too far?

It raises significant issues when a minister of health suggests we need a co-payment for GP visits when there is already a significant co-payment — an OPE.

Will the OPE be reduced by $6 if the co-payment is introduced? I doubt it.

It is interesting to look at overseas health payment schemes when thinking how we might work through this issue.

The 2013 OECD health report makes interesting reading and points out that Australia has the second highest gap in the world between what we pay GPs/non-proceduralists and what we pay specialists. We are just behind Belgium.

And while our GPs earn 1.3 times the OECD average, our specialists make 6.4 times the OECD average — not bad if you can get it.

Is it not strange that we spruik the benefits of our health system around the world (and it is not bad on international bench marks, at least for health professionals), but we then say of course it is built on our strengths in general practice, the 'filter' that handles patients and provides holistic care — but of course we only pay them a fraction of what we pay the specialists and proceduralists!

Do patients actually realise what is going on? Surely it is time for patients to assert their rights and for the peak bodies in the health professions to start looking at what they and their members are doing before we have something done to us. It is interesting that despite the negative press of the US healthcare system there are now more salaried doctors in America than non-salaried and the number is rising quickly. This is driven by the health insurance industry and it might be about to start here. What is wrong with a salaried system anyway? Many countries run their health systems on that basis. My European colleagues cannot understand why a rheumatologist makes a fraction of what an orthopaedic surgeon makes, for example.

So let's start a real conversation about this, in the interests of patients, not ourselves. The Consumers Health Forum has started the debate; it needs to be listened to, as these financial issues are significantly impacting on the community we should be serving.