



Empty Pockets: Why Co-payments are not the solution
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Executive Summary

Australia, like most other developed countries, is experiencing an increase in the demand for health care in conjunction with a rise in health care costs. This is due both to the ageing of our population (and consequent increase in chronic illness and multi-morbidity) and to the development of more sophisticated (and often more expensive) forms of treatment. This is leading governments, policy makers and other stakeholders to consider ways of managing health care expenditure to ensure it delivers value to the community.

One option often suggested as a strategy to increase the efficiency of our health system is to introduce co-payments for services which are currently 'free' (incur no charge at the point of use) or to raise co-payments for services currently incurring a charge. This paper discusses these options in the context of the current approach to co-payments in the Australian health system and is informed by recent consultations undertaken by the Consumers Health Forum into consumers' current experiences and views on health co-payments.

Currently, Individual co-payments comprise 17% of total health care expenditure in Australia and are the largest non-government source of funding for health goods and services. This represents a higher proportion of health funding than in most other OECD countries. Australia has no national policy on co-payments and there has been no comprehensive consumer or community consultation on this issue.

This means that co-payments are set by governments, health care providers and others independently without any guidance from the community or in the context of an overarching a policy framework. There are also a number of significant data and research gaps in our understanding of how co-payments impact upon consumers and providers. A comprehensive, effective and equitable policy on co-payments cannot be developed unless there is broad community consultation and additional research on this issue, in particular focussing on the impact of co-payments on people with chronic illnesses, multi-morbidities and disabilities.

There is good evidence that existing co-payments within the Australian health system are causing financial hardship for many consumers, in particular those with chronic conditions and/or on low incomes. There is also a significant body of international evidence that co-payments create barriers to access to health care for many consumers without decreasing overall health care costs. In summary, the main findings of research into co-payments in health care are that:

- The introduction of co-payments results in decreased access to health care (strong evidence)
- This decrease in access is proportional to the size of the co-payment (strong evidence)
- The impact of co-payments differs across different population groups and is greater for the elderly (strong evidence), people on low incomes (strong evidence) and people with chronic illnesses (medium level evidence)
- There is no evidence that the decrease in health service utilisation due to the introduction in co-payments is in unnecessary or low-value services. There is limited evidence that the decrease occurs in both high and low value services.

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- There is no evidence for overall cost savings as a result of the introduction of co-payments and limited evidence for increased downstream health care costs.

Introducing new co-payments into an already inconsistent and inequitable ‘system’ of co-payments risks compounding the existing problems and further disadvantaging those already experiencing difficulties affording their health care. Anxiety about proposal to introduce co-payments has come through strongly in responses to an online survey the Consumers Health Forum has conducted in recent weeks seeking respondents’ views and on consumers’ experiences in dealing with out of pocket health costs.

To date, the survey has drawn nearly 350 responses from people, more than 70 per cent of whom stated they had delayed going to the doctor when they needed to and half of whom attributed this delay to cost worries. Key findings of the survey include:

- Many consumers are already experiencing difficulty affording health care costs;
- Many consumers are failing to access needed health care due to its cost; and
- Any new co-payments – even if small – will further add to the financial difficulties being experienced by many consumers and create additional barriers to accessing appropriate care.

Improving our current ‘system’ of co-payments requires the development of a national comprehensive policy or set of underlying principles on co-payments. This should be based on extensive community consultation and informed by recent Australian-based research in this area.

There are more effective ways of managing health system expenditure without undermining equity of access, including workforce reform, improved practice management and changes to the way in which we pay health care providers.

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List of Findings

- **Co-payments will result in people delaying treatments, leading to higher health costs overall.**
- **There is no evidence to show there will be overall cost savings but there is a clear risk of compounding existing problems and further disadvantaging people.**
- **Co-payments will create more financial hardship, have a big impact on sick and poor people and compound existing disadvantage.**
- **Introducing co-payments will result in decreased access to health care.**
- **The report says existing co-payments already cause financial hardship for many consumers - particularly people with chronic conditions and/or on low incomes.**
- **The report says there is a significant body of international evidence to show co-payments create barriers to access for health care for many consumers without decreasing overall health costs.**
- **The report reveals a huge 17% of all total health care expenditure in Australia is now being funded by individual co-payments. It is now the largest non-government source of funding for health, goods and services and is significantly higher in Australia than most OECD countries.**

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Health co-payments issues – Summary

Problems with co-payments	Impact on consumers	Research findings	Potential solutions
Cause barriers to access	Lack of access to essential and preventive health care (in particular for people with chronic conditions and those in rural/remote areas)	Strong evidence linking co-payments to decreased access to health care	Undertake community consultation to identify community and consumer values and priorities for co-payments
Create financial hardship	Health problems become more serious due to the delay in treatment	Access barriers resulting from co-payments are proportional to the size of the co-payment.	Develop an integrated and comprehensive approach across the sector
Impact more on the sick and poor	Consumers forgo other expenses (such as food and rent) to afford medical care	The impact of co-payments is greater for the elderly (strong evidence), people on low incomes (strong evidence) and people with chronic illnesses (medium level evidence)	Implement a single safety-net, including Medicare, PBS and other health services
Compound existing disadvantage	Consumers experience stress and anxiety about the cost of health care. This can compound existing health problems.	No evidence that the decrease in health service utilisation due to the introduction in co-payments is in unnecessary or low-value services. There is limited evidence that the decrease occurs in both high and low value services.	Link co-payments to value so that consumers are encouraged towards the most cost-effective care option
Can create perverse incentives	Consumers seek less cost-effective forms of care (e.g. hospital emergency departments) as they are free (at the point of service)	No evidence for overall cost savings as a result of the introduction of co-payments and limited evidence for increased downstream health care costs.	Find more effective ways of increasing health system efficiency, e.g. workforce reform
Can delay cost-effective treatment – resulting in higher health costs overall	High health care costs can compound existing disadvantage resulting in a less equal society.		Increase research to address identified data gaps, in particular for people with chronic illness

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Definition of co-payments

People with an illness or disability can incur a wide range of costs associated with their condition. These include the direct cost of care (e.g. medical expenses); costs for additional non-health goods and services they require as a result of their condition (e.g. the cost of travel to receive treatment) and indirect costs that result from their condition (e.g. forgone salary due to an inability to work).

An important component of the costs associated with illness and disability are co-payments made for health and medical goods and services. Co-payments are the “out of pocket” payments that consumers make directly for care which are not rebated by Medicare, private health insurance or other sources.

Co-payments can form part of the total payment for a health good or service or they can comprise 100% of the cost.

Examples of different co-payments operating with the Australian health system are:

- The ‘gap’ payment for GP services (the difference between the fee and the Medicare rebate)
- The co-payment for PBS medicines
- The ‘excess’ charged for private hospital visits (the difference between the private hospital charges and rebates from private health insurance)
- The total cost of non-PBS medication
- The total cost of a dental or allied health consultation (for someone without private health insurance)

Consumer co-payments can be divided into two main categories: limited and open ended. Limited co-payments are those where the consumer pays a fixed amount, regardless of the overall cost of the service (for example co-payments for PBS medications). Open ended co-payments are those where the consumer pays an unlimited amount, often the excess over a fixed subsidy (for example the gap payment for GP and specialist services). These two types of co-payments impact differently on consumers. Only fixed co-payments are effective in reducing the risk associated with health care costs, as open ended co-payments leave consumers exposed to potentially unlimited costs.

There are also differences in the way in which co-payments are levied by health services and providers. Some forms of care require an up-front payment by the consumer of 100% of the fee for the service (e.g. a privately-billed medical consultation) with a rebate available at a later stage. In other cases (such as PBS-listed medications) the consumer generally pays only the consumer co-payment at the point of purchase.

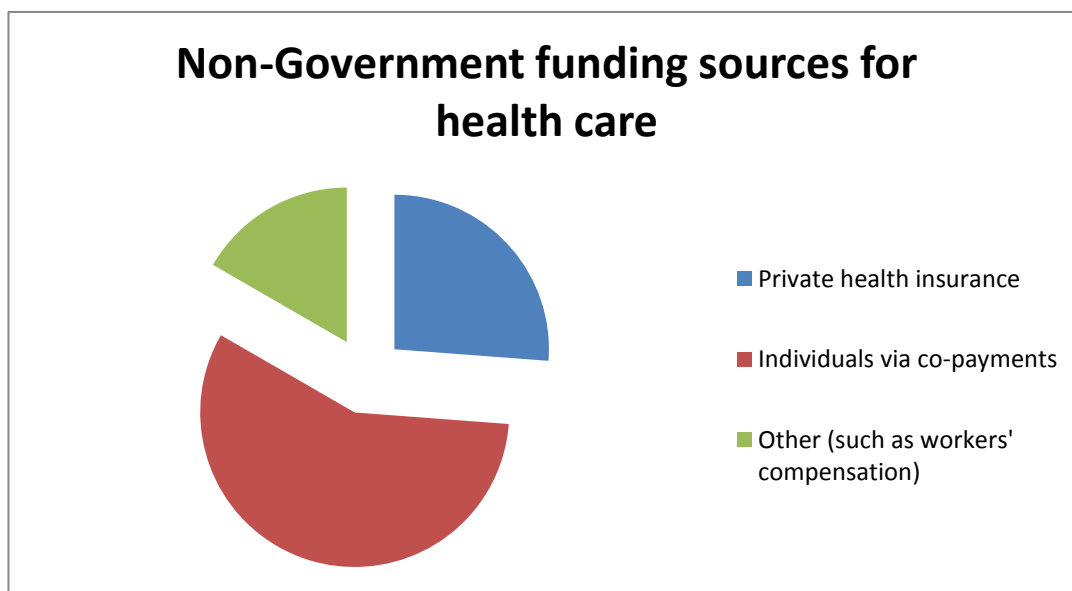
Co-payments are set via a range of mechanisms within the Australian health system. For some forms of care (e.g. private hospital services) the total fee for a good or service is set by individual private providers with government and/or private health insurance providing a rebate. For other forms of health care (e.g. PBS-subsidised medicines) a fixed co-payment is set by Government. For other health goods and services (e.g. many dietary supplements) consumers are required to pay the full price set by the manufacturer and/or retailer.

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This paper focusses on co-payments for health goods and services but it is important to remember that they are only one component of the overall economic impact of illness and disability on consumers, their carers and families and the community as a whole.

Co-payments in the Australian Health System

Co-payments comprise the third largest source of health funding in Australia, after Federal and State/ Territory Governments. They contribute over \$24 billion a year to the health system, and comprise 17% of health spending in Australia.



Co-payments fund a broad range of health goods and services. In 2011/12 almost 60% of the \$24.8 billion in co-payments for health care were for medicines (39%) and dental services (19%). A further 11.9% for medical services, 10.1% for aids and appliances and 7.8% for other health practitioner services.¹

The proportion of health funding contributed by co-payments varies significantly across different areas of the health system. For example, some forms of health care (such as medicines on the Pharmaceutical Benefits Scheme) are heavily subsidised, resulting in little or no out-of-pocket costs to consumers. For other health goods and services (for example, non-prescription medicines), consumers are often required to meet most or all of the cost themselves.

Percentage of total funding from consumer co-payments²

Public hospitals	2.5%
Private hospitals	11%
Medical services	12%
PBS Medicines	16%
Dental services	56%
Aids and appliances	69%
Non-PBS medicines	92%

¹ AIHW 2013a

² AIHW 2013a

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This means that in 2011/12 consumers contributed an average of 92 cents in direct payments for every dollar spent on non-prescription medications but only 12 cents in every dollar spent on medical services.

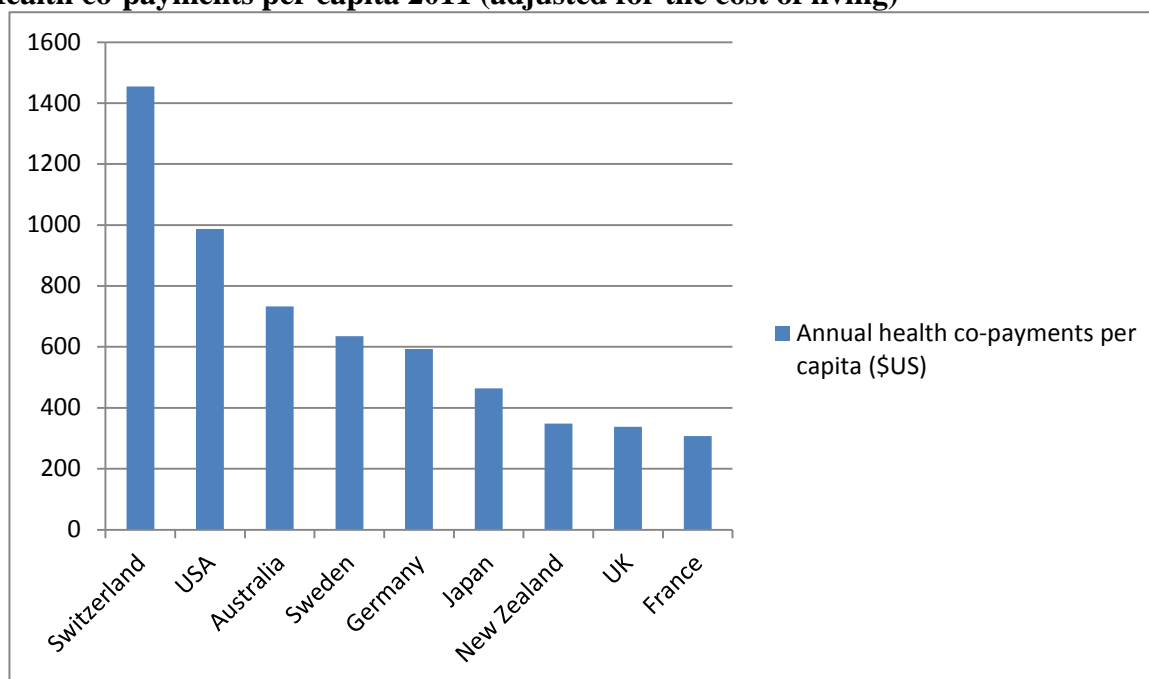
Over the past decade, Australians have been paying more for healthcare overall and a higher percentage of this funding is coming from co-payments. Between 2001–02 and 2011–12, funding by individuals grew by an average of 6.1% a year in real terms, compared with an average of 5.4% for total funding of health expenditure.³

The National Centre for Social and Economic Modelling (NATSEM) supported the finding of a trend towards increased health costs in a report prepared for the National Health and Hospitals Reform Commission (NHHRC) which states:

“Over the past decade, health expenditure has been one of the fastest growing areas of household expenses. More and more families are finding it difficult to stretch the family budget to meet the costs of healthcare that they would ordinarily consume, especially in an economic environment in which the costs of other necessities are also rising.”⁴

Australians pay for a higher proportion of their care through co-payments than citizens of most other OECD countries. The Commonwealth Fund⁵ has found that when health care spending is adjusted for the cost of living, Australians pay more in direct payments than all over countries surveyed, apart from the USA and Switzerland.

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



³ AIHW 2013a

⁴ NATSEM 2008

⁵ Squires 2013

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The Commonwealth Fund survey of sicker adults found that Australians with chronic conditions pay higher co-payments than average with 25% of those surveyed reporting that they paid over US\$1000 per year in co-payments. This was higher than people with chronic conditions in any other country, apart from the USA.⁶

Similarly, there is a wide variation in the impact of co-payments on people with different illnesses and disabilities. People with conditions that can be largely treated by GPs or within the public hospital system generally incur lower co-payments than those with conditions that require allied health care and over-the-counter medicines.⁷ This is the case independently of the length or severity of the illness/disability and its impact on both individuals and society as a whole. In fact, people with ongoing chronic conditions often end up receiving lower levels of subsidy for their health care than those with one-off or self-limiting conditions.⁸

Another result of this ad hoc and uncoordinated approach to co-payments is that some people receive almost all their health care free at the point of service, and others, with conditions which may be more serious or longer term, face crippling costs for their treatment. For example, someone receiving emergency surgery for a one-off event, such as removal of an appendix in a public hospital, can incur no out-of-pocket costs for their treatment, whereas someone with a life-long genetic condition (such as Cystic Fibrosis) can incur high ongoing costs. This results in an inequitable allocation of health care resources and has a particularly negative impact on people with chronic conditions.

Hypothetical example

Paula and Kim are both public servants earning around \$80 000 per year. Last year both women required health care costing \$20 000 (the total cost of health goods and services for each woman – not the total out-of-pocket payments). Paula's health care occurred in relation to the premature birth of her baby which involved an extended hospital stay in a public hospital. Kim's health care requirements arose from her severe rheumatoid arthritis for which she needs treatment from a GP, specialist and physiotherapist. She also requires a range of medications (both prescription and non-prescription) to manage the symptoms of her condition.

Over the course of the year, Kim contributed \$8 000 in co-payments for the health care she required while Paula was not required to make any co-payment. This is despite the fact that Paula's condition was a one-off event and Kim's condition is likely to last her entire lifetime.

Another important feature of co-payments within most health systems is their differential impact on consumers, depending on their income levels. One of the disadvantages of consumer co-payments is that they tend to be less equitable than other forms of health funding and therefore reduce the overall fairness of a country's health system.

This is because, when compared with other forms of health funding, direct co-payments impact very differently across the community. Public insurance – such as Medicare – shares the cost of health care among all tax payers. Private health insurance funds share the cost among all health fund members (who in addition receive a significant taxpayer subsidy). However, the cost of direct payments falls completely onto the individuals concerned. This

⁶ Schoen and Osborn 2008

⁷ For example, a person without private health insurance will receive a \$36 rebate for a standard GP consultation but in general would receive no rebate for an allied health service

⁸ This is partly because most of the safety-net and compensatory arrangements are based on health care costs incurred over a 12 month period and do not take into account total lifetime expenditure

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means that the sick pay more than the healthy and the poor pay more – as a share of their income – than the well-off.

Hypothetical example

Jasper earns \$400 a week and Julia earns \$2000. A co-payment of \$40 for a medical service represents 10% of Jasper's total weekly income but only 2% of Julia's. Therefore, in the absence of any safety-net or other compensatory mechanisms, the introduction of the co-payment will disproportionately impact upon Jasper. This effect is even more pronounced if the co-payment is seen in proportion to the discretionary income of both Jasper and Julia (their income after essentials, like food, housing and utilities are paid for). Jasper's discretionary income is \$50 per week and Julia's is \$800 per week. Therefore, the co-payment will take up 80% of Jasper's discretionary income for that week but only 5% of Julia's.

Given that sicker people tend also to be poorer than average – as illnesses and disabilities often adversely affect earning capacity – the overall impact of increasing co-payments for health care, without introducing appropriate safety-net or compensatory measures, is to shift the burden of health funding from the affluent and healthy to the sick and poor.

“As there are few bulk billing practices in our area we pay a large gap when go to the GP. Many young Aussies studying and working in low paid jobs are already neglecting their health because they cannot afford Dr and dentist fees and charges and possibly prescription medicines!” recounts one consumer via our Facebook page.

To some extent, this differential impact can be corrected via safety-nets and other compensatory mechanisms but in practice it is difficult to accurately target consumers adversely affected by co-payments to ensure they do not experience barriers to accessing care. This issue is discussed in more detail, below.

Safety-nets

Currently there are two main safety-nets in place within the Australian health system which target consumers facing high levels of co-payments. They are the Medicare safety-net and the PBS safety-net. A tax-based rebate system for out-of-pocket medical and health costs (the medical expenses tax offset) is currently being phased out but still applies to some consumers.

Medicare Safety Net

The Medicare safety-net^[1] provides additional rebates for high-level users of out-of-hospital medical services, such as GP and specialist consultations, ultrasounds, x-rays and blood tests. There are three different levels of the Medicare safety-net: Original; Extended Concessional and FTB (A); and Extended General. The first level meets the cost of the 'gap' (i.e. it rebates 100% of the schedule fee) for out-of-hospital services, once an annual threshold is reached.

The next two levels pay for 80% of out-of-pocket costs for most out-of-hospital services (some services are capped), with two different thresholds depending on consumers' income level and responsibility for dependents. Currently the threshold for the Extended Medicare

^[1] Website of the Department of Human Services, accessed 21 January 2014
<http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net>

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Safety-net is \$1221.90 but from 1 January 2015 this will increase to \$2000 for families, couples and individuals.⁹

The Schedule Fee is the price the government sets for each Medicare-funded service. This bears no direct relationship to the fee for the service (which is set by the provider) and often consumers will be charged much more than the Schedule Fee. The Medicare benefit (i.e. the amount the Government pays) will be 75% or 85% of the Schedule Fee depending on whether the service is delivered in a hospital or in a community setting, such as specialist consulting rooms. A consumer's co-payment for a medical service includes both the difference between the Medicare Benefit and the Schedule Fee and any amount the provider charges above the Schedule Fee. The 'Gap' Medicare Safety Net only counts the first amount and not the second, which is covered by the other two levels of the Medicare Safety Net.

Hypothetical example

Gail visits a medical specialist and pays \$130 for the consultation. \$85 of this she receives back as the Medicare benefit for the consultation. Her total co-payment for this service is therefore \$45. As the schedule fee for the consultation is \$100, her \$45 co-payment is made up of the \$15 'gap' between the schedule fee and the Medicare benefit and \$30 in an additional payment above the schedule fee. As Gail is eligible for both the Original and Extended Concessional safety-nets she is eligible to receive an additional rebate of \$39 comprising 100% the \$15 gap (Original safety-net) and \$24 as 80% of the remaining \$30 (Extended concessional safety-net). Thus her total out-of-pocket cost for the service is \$6.¹⁰

As the example above demonstrated, the Medicare Safety Net provides some consumers with limited assistance in meeting their out-of-pocket health care expenses. However, overall CHF is concerned that they are inadequate to address the existing problems arising from co-payments (identified above) and the possible introduction of new co-payments. This is particularly concerning given the increase in the threshold for the Extended Medicare Safety Net (EMSN) announced in the 2013-14 Budget, (see above). This increase will make it even more difficult for consumers to receive additional rebates for high out-of-pocket costs.

Pharmaceutical Benefits Scheme Safety Net

The PBS safety-net¹¹ reduces the cost of PBS-listed medicines for high level users. Once an annual threshold is reached, the price of additional medicines drops for the rest of the year. There are two levels of the PBS safety-net: general and concessional. Once the annual threshold is reached, general consumers receive their medicines at the concessional price and consumers with a concession card receive them free. Some costs associated with PBS medicines, such as brand premiums are not counted towards the safety-net thresholds.

⁹ Federal Budget 2013/14 papers

¹⁰ This assumes that Gail had the cash up-front to access this service and was both aware of and able to fulfil the administrative requirements to access the safety-nets. These assumptions cannot be made in practice for a range of reasons – as discussed in the section on 'Problems with existing safety-nets', below.

¹¹ Website of the Department of Human Services, accessed 21 January 2014
<http://www.humanservices.gov.au/customer/services/medicare/pbs-safety-net>

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The medical expenses tax offset

Medical Expenses Tax Offset (METO)¹² is currently being phased out. However, those taxpayers who received the offset in their 2012–13 income tax assessment will continue to be eligible for the offset for the 2013–14 income year if they have eligible out-of-pocket medical expenses above the relevant claim threshold. Similarly, those who receive the tax offset in their 2013–14 income tax assessment will continue to be eligible for the offset in 2014–15. The offset will continue to be available for taxpayers with out-of-pocket medical expenses relating to disability aids, attendant care or aged care expenses until 1 July 2019.

The MTEO provides a tax offset of 20% – 20 cents in the dollar – of net medical expenses over \$1,500 for the financial year. There is no upper limit on the amount that can be claimed. Medical expenses which qualify for the tax offset include payments to doctors, including GPs and specialists, nurses, both public and private hospitals, dentists, and for medical aids prescribed by a doctor, artificial limbs or eyes and hearing aids.

Other forms of assistance

There are other forms of assistance with health care costs provided to consumers who have high health care expenses, low income or who are otherwise eligible (e.g. veterans). These include:

Health Care Cards

Health Care Cards (HCCs)¹³ are issued by the Federal Government to people on low incomes, recipients (and in some cases ex-recipients) of some allowances (such as disability pension, mobility allowance and carer allowance) and people caring for foster children. HCCs entitle recipients to the concessional rate of PBS pharmaceuticals and some other concessions for health, education and transport expenses from federal, state and local government as well as private providers.

Department of Veterans Affairs

The Department of Veterans' Affairs (DVA)¹⁴ provides an extensive range of benefits and services to eligible veterans, current and former serving members and their families. These include:

- general practitioner services
- medical specialist services including pathology and radiology
- allied health services, egg podiatry, physiotherapy and other allied health services
- dental care
- community nursing
- spectacles and hearing aids
- care in public and private hospitals including day procedure centres
- home support services
- Subsidised pharmaceuticals under the Repatriation Pharmaceutical Benefits Scheme (RPBS).

¹² Website of the Australian Taxation Office, accessed 21 January 2014

<http://www.ato.gov.au/Individuals/Income-and-deductions/Offsets-you-can-claim/Medical-expenses/>

¹³ Website of the Department of Human Services, accessed 21 January 2014

<http://www.humanservices.gov.au/customer/services/centrelink/health-care-card>

¹⁴ Website of the Department of Veterans Affairs, accessed 19 January 2014

<http://www.dva.gov.au/eligibilityandclaims/Pages/EligibilityandClaims.aspx>

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- aids and appliances to assist entitled persons to remain living independently in their homes

There are two main categories of people eligible for health care subsidies from DVA: Gold Card holders; and White Card holders.

Holders of a Gold Card (the Repatriation Health Card - For All Conditions within Australia) are entitled to the full range of health care services at DVA's expense, including medical, dental, optical care and subsidised pharmaceuticals. They are also entitled to aids and appliances to help them to remain in their home.

Holders of a White Card (the Repatriation Health Card – For Specific Conditions) are only entitled to be treated at DVA's expense including subsidised pharmaceuticals for their accepted service related disabilities or illnesses.

State and Territory programs

State and Territory Governments sometimes also provide subsidies for some medical and health care expenses through individual schemes targeting specific groups of consumers.

In particular, the provision of medical aids and appliances for eligible patients is a state or territory government responsibility. For example, the Victorian Aids and Equipment Program¹⁵ (A&EP) provides people with a permanent or long-term disability with subsidised aids, equipment, home, and vehicle modifications. The program aims to enhance the independence of people with a disability in their own home, facilitate their participation in the community and support families and carers.

Other arrangements

Some individual providers also implement their own safety-net or concessional billing arrangements for people on low incomes or for high level users of medical services. Examples of these arrangements include practitioners who bulkbill (or concessional bill) pensioners and/or children and local councils who provide discounts on home help services for pensioners.

For example, the Reynolds Road 7 Day Medical Centre¹⁶ in Perth advertises that it bulk bills children up to 12 years old, aged pensioners and Veterans Affairs card holders and charges a discounted fee to Health Care Card holders.

There are also some individual targeted schemes for people who use specific forms of health and medical care, such as the Continence Aids Payment Scheme¹⁷, which provides subsidies for people requiring the long-term use of continence products.

Problems with existing safety-nets

As discussed above, there are a number of safety-nets which have been put in place to help consumers afford health goods and services. However, while these can help address some of the equity and efficiency problems that arise with co-payments, they do not provide adequate

¹⁵ Website of the Victorian Department of Human Services, accessed 18 January 2014
<http://www.dhs.vic.gov.au/for-individuals/disability/aids-and-equipment>

¹⁶ www.doctors-4u.com <http://www.doctors-4u.com/perth/pbbill.htm>

¹⁷ Website of the Department of Health, accessed 18 January 2014
<https://www.health.gov.au/internet/main/publishing.nsf/Content/Continence-2>

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assistance to many groups of consumers. In some cases they have an opposite effect to that which is intended, increasing inequities within the health system and discouraging the most efficient use of resources. The lack of a broad community consultation process on health co-payments means that these safety-nets have been developed without any underlying principles or policy guidelines and without reference to the values or priorities of consumers.

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

- they are difficult to understand and often require consumers to keep records of their expenses and apply for benefits. Some consumers miss out on receiving the benefits of safety-nets due to administrative problems or because they are not aware of their eligibility;
- their application is inconsistent (some operate on an individual basis, some on a family basis, some use calendar year outlays and some use financial years). Frequent changes are made to safety-net arrangements which affect consumers' eligibility and the level of benefit they receive. For example, the MBS safety-net now includes three different eligibility categories with different thresholds plus caps for some services). These changes make it difficult for consumers to understand, and increases the administrative complexity of the system.
- they often do not address the need for high up-front payments for health care (consumers are often required to pay the full cost of a service and apply afterwards for a rebate) which can prevent access to services for people with cash flow problems (health problems often coincide with cash flow problems due to the impact of illness on the capacity to work);
- they often don't support the choice of the most effective or efficient care option (for example people who reach the PBS safety-net will have a greater incentive to seek a pharmacological treatment for their condition, rather than a medical or allied health treatment, even if it is not the most cost-effective);
- they are based on annual expenditure which advantages consumers whose health care expenses occur in a short timeframe over those who have ongoing conditions requiring lower levels of care for longer periods;
- mechanisms to address inequity, such as health care cards, identify people on the basis of income level or carer status, but do not accurately target those who have difficulty affording health care. There are many consumers who do not qualify for health care cards or pensions but who experience difficulty in meeting their health care costs;
- the safety-nets operate in isolation so that there is no consistent approach across all forms of health and medical care. This advantages people whose health care needs focus on one specific type of care (e.g. medical or pharmaceutical) but disadvantages consumers who require care from a broader range of providers and/or use medical aids and appliances; and

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

Hypothetical example

Ravi and Antonio are both single men in their 20s who work in the retail sector earning \$65k per annum. Ravi is generally in good health and rarely requires any health or medical care. However, one year he injures his knee playing football and requires a total knee reconstruction and three months of rehabilitation treatment. This costs him a total of \$3500 in out of pocket costs that year. Antonio has Hepatitis C and requires regular health care, including frequent GP and specialist consultations, prescription medication, blood tests, over-the-counter supplements and Chinese medicine. He also sees a psychiatrist for mental health issues related to his chronic condition. His overall out-of-pocket health care expenses for a year are \$1000. Because the Medicare safety-net is calculated on an annual basis and is restricted to medical services Ravi receives a \$2100 rebate via the Medicare safety-net. However, Antonio receives only \$80.

Over a five year period, Ravi's health care expenses total \$3800 and Antonio's are \$5000. However, Ravi receives a total of \$2100 in Medicare safety-net rebates and Antonio receives only \$400.

Due to the above problems, the existing safety-nets cannot be assumed to provide adequate protection for consumers struggling to meet their health care expenses. Unless a single, comprehensive and well-targeted safety-net can be developed (discussed in more detail below), any increase in co-payments risks compounding the access, equity and efficiency problems inherent in the current system.

Co-payments and private health insurance

Co-payments also occur in relation to privately insured services. Currently, 55% of Australians hold some form of private health insurance¹⁸ and as well as their monthly premiums can incur additional co-payments when accessing privately insured services. Co-payments for people with private health insurance may include a one-off excess for hospital treatment, regular payments per day of hospital admission of 'gap' payments for allied health services. Monthly premiums are not classed as co-payments for health care and are therefore not included in calculations of individual payments for health care.¹⁹ However, co-payments associated with using privately insured services are included in this figure.

Excess and co-payment conditions are included in approximately three quarters of all private health insurance policies held in Australia. These co-payments can be significant. PHIAC quarterly statistics for June 2013 show that the average co-payment for one episode of hospital treatment was \$307 and for non-hospital services it was \$47. There is also evidence that co-payments associated with private health insurance impact more on people. AIHW data²⁰ shows that in 2010-11 people with health insurance aged 65 and over who had a hospital admission spent an average of \$1171 on out of pockets for hospital services.

"I am relatively lucky enough to be able to afford private health cover (just- we are considering reducing our level though), unlike my pensioner mother who has many health

¹⁸ PHIAC 2013b

¹⁹ Such as the AIHW figures, cited in the pie chart above.

²⁰ AIHW 2011 Table 3.16 pg 42

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issues. I am concerned that introducing this fee will encourage more people to go to ER for health issues that could quite easily be treated by the local GP. Once again the already overloaded, underfunded, under resourced hospital system will suffer!!” Consumer from NSW

Private health insurance can assist some consumers with managing their health care expenses but does not provide an adequate solution for many people with high health care costs. Fixed rebates for services when consumers are still required to pay an open ended co-payment (such as those required for ancillary services by most forms of private health insurance) do not provide consumers with ‘insurance’ in the sense of capping their risk as consumers are still exposed to potentially unlimited costs.

High level users of ancillary services often find that their rebates cover less than half of the cost of a visit, with yearly limits imposed on the total benefits paid which can run out quickly for people needing frequent treatment. Also, there has been an increasing trend towards policies with lower premiums but more restrictions and exclusions for selected forms of treatment and higher co-payments when the insurance is used.²¹ The Private Health Insurance

Administration Council (PHIAC) reports that in 2012, 60 per cent of people took out cover with exclusions, up from 40 per cent in 2003.²² Even when consumers can afford the premiums, they can struggle to afford the co-payments associated with care, leaving them without adequate coverage.²³ This can result in consumer dissatisfaction, as indicated by PHIO’s report that complaints about exclusions and restrictions have increased in recent years.²⁴

Even when private health insurance assists consumers with costs associated with private care, all Australians rely on the public health system for some services. Therefore private health insurance cannot be seen as a solution to the problems associated with co-payments across the spectrum of the health system.

Overview of research into co-payments

A wide range of research has been conducted on co-payments in the health system however there are also significant limitations to this research, in particular in its relevance to the Australian context.²⁵ Despite this, there are some clear and consistent findings across the broad range of studies that have been conducted about the impact of co-payments on utilisation of health goods and services and, in particular, the adverse effect they can have on access to health care for vulnerable groups. These findings are supported by Australian-based research and feedback from consumers obtained by CHF through its consultation processes.

A comprehensive review of the literature on co-payments is outside the scope of this paper, however, the following section provides an overview of the main conclusions of this research, together with some examples of key studies and relevant Australian examples.

In summary, the main findings of co-payment research are that:

²¹ PHIAC 2012a

²² PHIAC 2012b

²³ Sydney Morning Herald *Private Health Insurance: one in the hip pocket*

<http://www.smh.com.au/nsw/private-health-insurance-one-in-the-hip-pocket-20131227-2zzf3.html>

²⁴ PHIAC 2012a

²⁵ See the section on the limitations of research and data gaps, below

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- The introduction of co-payments results in decreased access to health care (strong evidence)
- This decrease in access is proportional to the size of the co-payment (strong evidence)
- The impact of co-payments differs across different population groups and is greater for the elderly (strong evidence), people on low incomes (strong evidence) and people with chronic illnesses (medium level evidence)
- There is no evidence that the decrease in health service utilisation due to the introduction in co-payments is in unnecessary or low-value services. There is limited evidence that the decrease occurs in both high and low value services.
- There is no evidence for overall cost savings as a result of the introduction of co-payments and limited evidence for increased downstream health care costs.

These points are discussed in more detail, below.

Access issues

There is strong evidence that the introduction of co-payments for health goods and services results in an overall decrease in utilisation.

For example, following the January 2005 increase in PBS co-payments a significant decrease in dispensing volumes were observed in 12 of the 17 medicine categories, including anti-epileptic medicine, anti-Parkinson's treatments, combination asthma medicines, insulin and osteoporosis treatments. This decrease in utilisation was observed in both general and concessional patients. On the basis of these findings, the authors suggest that the increase in co-payments impacted on patients' ability to afford essential medicines and that it was particularly concerning that despite the PBS safety-net, the co-payment increase had a particular impact on utilisation for concessional patients.²⁶

This finding is supported by international evidence, such as comprehensive USA-based study of more than 10 million prescriptions found that those which had co-payments of \$40-\$50 dollars were four to five times more likely to be abandoned at pharmacies compared to those with no co-payments.²⁷

Another study on the use of hospital emergency departments found that at least 1 in 5 patients altered their care-seeking behaviour because of co-payments and one in every 10 patients either delayed seeking care or avoided care altogether.²⁸

However, the overall impact on utilisation, there is also evidence that co-payments can increase utilisation among some groups while reducing it in others. For example, one South Korean study found that substantial increases in co-payment amounts for insured services, coupled with additional out-of-pocket payments for uninsured services, resulted in a significant drop in the utilisation of ambulatory services overall. However, the utilisation rates by higher-income users increased while those lower-income earners decreased.²⁹

²⁶ Hynd et al 2008

²⁷ Shrank et al., 2010

²⁸ Reed et al., 2005

²⁹ Kim et al 2005

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Despite the overall decrease in utilisation, there is no evidence that this occurs in relation to unnecessary or low value services. In fact, the limited evidence available suggests that, while co-payment increases often reduce overall demand, they do not result in a more rational use of health services. For example, a Cochrane Collaboration Review of 30 studies of cap and co-payment systems for pharmaceuticals concluded that:

..... cap and co-payment policies can decrease overall drug use and decrease third-party drug spending. But reductions in drug use were found for both life-sustaining drugs and drugs that are important in treating chronic conditions, as well as in other drugs. Although insufficient data on health outcomes were available, large decreases in the use of drugs that are important for peoples' health may have adverse effects. This could lead to an increased use of healthcare services and therefore, overall spending.³⁰

While the research on co-payments in the Australian context is limited, there is evidence that existing co-payments are creating barriers to access among some groups of consumers, in particular those with chronic conditions.

For example, the Commonwealth Fund's 2013 International Health Systems³¹ survey and its 2008 Survey of Sicker Adults³² found significant evidence that co-payments were creating an access barrier for many consumers. Among the survey's findings were:

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

These findings are reflected by other research into the impact of health care costs on specific consumer groups. A study on the financial impact of Chronic Obstructive Pulmonary Disease³³ found that many consumers experienced significant financial stress due to the compounding impact of rising costs for the different types of care required. On this basis the authors concluded:

The costs associated with living with COPD make it difficult for patients and their families to afford necessary living expenses while also paying health care expenses. This is alarming within Australia where a well-funded universal health insurance system is in place. Rising co-payments for medications and private medical consultations, poorly subsidised health support (e.g. home oxygen), non-health logistics (e.g. transport) and eligibility barriers for existing social support are making chronic illness management seriously economically stressful, especially for those with low incomes, including the retired.

³⁰ Austvoll-Dahlgren A et al 2008

³¹ Squires 2013

³² Schoen and Osborn 2008

³³ Essue et al 2011

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The cost of dental care was found to be a particular barrier to access by the Australian Bureau of Statistics in its annual Patient Experience Survey³⁴. It found that almost one in five (18 per cent) Australians aged 15 and over and over one quarter (27 per cent) of Australians in the age group of 25 to 34 years who needed to see a dental professional had delayed seeing or had not seen a dentist due to cost. The survey also identified specific barriers to access among a number of consumer groups:

"People living in areas of greatest socio-economic disadvantage were twice as likely to delay going or not go to a dental professional due to cost, compared with people living in areas of least socio-economic disadvantage (24 per cent compared with 12 per cent). People living in outer regional, remote or very remote areas of Australia were also more likely to delay going or not go to a dental professional due to cost (21 per cent) compared with those living in major cities of Australia (17 per cent)."

Another research project³⁵ conducted by the Chronic Illness Alliance found that rural and regional Australians with chronic illnesses are spending up to 27% of their total household income on health-related expenses. This study found that the greatest contributor to both poverty and financial distress among participants was the cost of medications, representing between 21%–31% of total health care costs. 20% of households with incomes of \$25 999 or less per annum in the study reported that medication costs caused them major financial problems.

People with mental illnesses are another group which reports experiencing hardship due to health care costs. A [survey](#)³⁶ by mental health body SANE has found that the majority of respondents reported having to choose between paying for health care or other essentials, such as food, on at least one occasion. Specifically, 42% of respondents reported that they had not filled scripts for medication due to cost, 96% reported that they were unable to afford essentials such as food at some point during the year and 29% reported having been contacted by debt collectors in past year.

Richard's story: My illness means periodically managing a roller coaster of paranoia and mood swings. This can be challenging enough, without added financial stress and feelings of hopelessness. When I see my psychiatrist it costs \$185.00 per half hour –simply to oversee a change in medication. Part of this is later refunded but it's very difficult for vulnerable people to come up with large amounts of cash at the very time help is needed. Richard McLean 2009, diagnosed with Schizophrenia at 22³⁷

Some insight into the differential impact of co-payments on people with chronic conditions is provided by a study showing that consumers respond differently to co-payments depending on their stage of illness. The research found that consumers with a known and established chronic condition, and where they understand the effect and value of the drugs were more likely to change their consumption patterns (for example switching to generic versions of their medicines) compared with consumers with newly diagnosed conditions who were more likely to absorb the costs of the co-payments.³⁸

³⁴ Australian Bureau of Statistics 2012

³⁵ Walker 2004

³⁶ SANE 2009

³⁷ Sane 2009

³⁸ Gibson et al 2005

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There is little research conducted specifically on the impact of co-payments on preventive health care. However, the high number of potentially avoidable GP-type hospital presentations also suggests that many people are not accessing preventive care in the community, due to the cost of the care or other access issues. The AIHW³⁹ found that there were 2.1 million potentially avoidable GP-type presentations to emergency departments in major public hospitals in a twelve month period (2011/12 figures). This accounted for 38% of all presentations at these hospital emergency departments.

These findings have been supported by the Productivity Commission⁴⁰ which found that between 600,000 and 750,000 public hospital admissions could be avoided annually with an effective community intervention in the three weeks prior to hospitalisation. Given that an average hospital admission costs at least \$5000 while a community intervention to prevent that admission would cost about \$300,⁴¹ this finding has been used to argue for increasing access to primary health care (rather than reducing it via increased co-payments) in order to improve the overall cost-effectiveness of the Australian health system.

Equity issues

There is widespread evidence from both Australian and international evidence that co-payments for health care adversely impact upon population groups already experiencing difficulties accessing care. These groups include the elderly, people on low incomes and those with chronic illnesses.

One systematic review of international research on co-payments in a number of countries over the period 1990-2011 concluded that *“the empirical evidence on the distributional consequences of co-payment indicates that individuals with low income and in particular need of care generally reduce their use relatively more than the remaining population in consequence of co-payment.”*⁴²

Another review article examined the effects of out-of-pocket payments on the elderly in OECD countries, specifically taking income, gender and education into account. It showed that out-of-pocket payments, as a proportion of income, were higher for women, those with lower education levels, and those with lower income.⁴³

The evidence for the impact of co-payments on the elderly is particularly strong. One five-year cohort case-control study of Medicare beneficiaries in the USA showed that ambulatory co-payments resulted in a decrease in outpatient ambulatory visits and an increase in in-patient days and hospital admission rates for the patients who were liable for co-payments.⁴⁴

It also found that those with the highest hospital admissions were black, of lower educational level and lower socio-economic status demonstrating that the impact of co-payments is greatest among the most vulnerable groups.

³⁹ AIHW 2013b

⁴⁰ Productivity Commission 2013

⁴¹ John Dwyer

⁴² Kiil A, Houlberg K. 2013

⁴³ Corrieri et al., 2010

⁴⁴ Trivedi et al., 2010

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This finding was reflected in other large study of more than two million insured in a West Coast state of the USA which showed significant decreases in emergency department and hospital utilisation rates as a result of increasing co-payments. It was particularly pronounced for patients from lower socio-economic backgrounds.⁴⁵

One study reviewing a range of evidence in this area concluded:

“These studies inevitably showed that the more vulnerable groups in society, whether by age, gender or socio-economic status are the ones who have their health service access most compromised by co-payments. This further justifies the exploration of alternate mechanisms to effect cost-saving and challenges of excess utilisation.”⁴⁶

Australian-based research and consumer feedback also indicates that consumer co-payments also impact differently on people according to their geographic location and their specific type of illness or disability. People living in rural areas typically incur higher co-payments for health services than do people in urban areas for the same services. This is due to a number of factors, including the higher cost of delivering care in the bush and lower levels of competition in rural areas which often have medical and health workforce shortages⁴⁷.

“Whilst I have not delayed seeking assistance the size of the gap between GP fee and Medicare benefit is becoming an increasing concern. Based on last GP consultation that gap is 52% which is fast moving away from affordable access. The problem is exacerbated by the fact that the GP practice does not routinely bulk bill. When this is done it is at the discretion of GP. Routine bulk billing is not limited to my practice - in fact no GP practices in our large rural city bulk bill as a matter of routine.” Consumer from NSW

“Living in the country I do have the added cost of distance to get to my GP. Two years in a row I have had operation and added cost of getting to Adelaide to RAH for appointments. I also at different times have seen Specialists to do with my Anxiety and Depression and sometimes had to pay a gap. Some medications there may be a gap payment and or various tests etc. I would not like to have to pay for anymore gaps. I did not set out to deliberately sabotage my life so that I would end up on Benefits....” Consumer from SA

“One day of a fortnight of my earnings goes to my medication alone. Just so I can work and live a life. I also have to have supplement drinks so I don't starve (gastroparesis) and I don't get any assistance with cost. It is difficult to manage a chronic illness (or more) in a medical setting that is based in acute medicine. It would be great to have support to work and be a functional member of society. Rather than having to struggle on alone in a system that doesn't support non-acute illnesses.” Consumer from VIC

⁴⁵ Hsu et al., 2006

⁴⁶ Shung-King 2011

⁴⁷ Walker 2013

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Efficiency issues

One of the arguments often made for the introduction of consumer co-payments is that they can help send price signals to consumers and so discourage the excessive use of health services.⁴⁸

This is one reason often given by governments for introducing co-payments, although, as discussed below, there is significant evidence that a large number of Australians are currently experiencing barriers to accessing basic and preventive health care services.⁴⁹

There is little evidence that the introduction of co-payments acts to increase the efficiency of health care resource use. In practice, the research shows that result of co-payments is to shift the cost of health care from governments to consumers. This may have a short-term impact on program budgets but can often result in higher longer term health care costs to the community.

Overall, a review article in this area concluded:

“there is inconclusive evidence that co-payments reduce health care costs. On the contrary, the limited available evidence suggests that health care costs, instead of being “curbed” are just delayed by preventable conditions not being treated, chronic diseases being poorly controlled and greater hospitalisations rates occurring later on. This cancels out the short-term benefits of decreasing health care costs and compromises the ultimate goal of improving health outcomes in a patient-centred versus a cost-centred health care system. In reality therefore costs are simply shifted from funders onto users, with potentially catastrophic economic effects for households in contexts of poverty.”⁵⁰

This conclusion is supported by a recent study of nearly 900,000 people in the United States found that increases in co-payments for ambulatory care resulted in a reduction in GP visits but also by significant increases in hospitalisation. This impact was particularly strong for people with low incomes, low levels of education and with chronic conditions. On the basis of this research the authors concluded that “co-payments “may have adverse health consequences and may increase total spending on health care”.⁵¹

Evidence from another article suggests that savings on drugs and prescriptions are cancelled out by a later increase in hospital admissions due to poor drug adherence and more disease complications, but this is based on small numbers.⁵² The potential effect of this is clearly demonstrated in the case of Korea, where over-utilisation by wealthier patients cancelled out the “cost-savings” of decreasing utilisation by poorer patients.

Another large US-based study examined the direct and indirect effect of co-payments on several preventative measures (mammography, cervical screening, blood pressure screening and preventive counselling).⁵³ Overall, the research found that co-payments led to a statistically significant decline in utilisation of all preventive measures, apart from blood pressure screening. On this basis, the authors conclude that policy makers must give due

⁴⁸ Barnes 2012

⁴⁹ See Britt et al 2013

⁵⁰ Shung-King 2011

⁵¹ Trivedi et al 2010

⁵² Choudry et al., 2010

⁵³ Solanki et al., 2000

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consideration to removing cost-sharing for all preventive activities, given the potential health promotion value of such health care interventions.

While there is only limited research on the relationship between the level of the co-payment and its impact on health care utilisation, one study also found that even small co-payments could affect access to cost-effective services in specific population groups. *Relatively small co-payments were associated with significantly lower mammography rates among women who should undergo screening mammography according to accepted clinical guidelines. For effective preventive services such as mammography, exempting elderly adults from cost sharing may be warranted.*⁵⁴

Proposals to introduce additional co-payment(s)

Recent proposals to increase co-payments for health care, for example a \$6 co-payment for each trip to the GP and up-front emergency department fees, have been made in submissions to the Commission of Audit and discussed in the media.⁵⁵

One paper prepared by Terry Barnes for the Australian Centre for Health Research⁵⁶ argues that such a co-payment would reduce “*reduce avoidable demand’ and offer ‘a simple yet powerful reminder thatwe have a responsibility to look after our own health’*”⁵⁷ A similar scheme was mooted and then abandoned during the Hawke era and much of this current proposal is based on the 1991 policy.

The paper argues that there is widespread overuse of GP services but does not provide any supporting data for this assertion. Research on health services utilisation shows that Australians are going to the doctor much more often than we did 20 years ago⁵⁸, however, there it is no evidence that this growth is made up of frivolous or inappropriate use. Due to the ageing of our population and the increase in chronic disease rates, it should be expected that our demand for GP services would increase.

In fact, despite an overall increase in utilisation of GP services there is also robust evidence for the under-use of primary health care services, particularly among men, Indigenous Australians and people from lower socio-economic groups⁵⁹. This under-use occurs in particular in the area of preventive GP services and causes increased ‘downstream’ costs as untreated health problems become more serious and require more expensive care.

Because there is no coordinated approach to co-payments (or the cost of illness and disability generally) across the spectrum of the health system, the inequity in the impact of co-payments on consumers is often not obvious to governments, policy makers and service providers. A small increase in PBS co-payments by the Federal Government may seem unlikely to cause hardship to consumers when considered in isolation.

⁵⁴ Kiil A, Houlberg K. 2013

⁵⁵ For example, the Australian Centre for Health Research 2013

⁵⁶ A thinktank funded by private health insurance funds

⁵⁷ The Australian Centre for Health Research 2013

⁵⁸ Britt et al 2013

⁵⁹ Britt et al 2013

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For example, in support of a proposed \$5 co-payment for GP services, Terry Barnes stated *“This is very affordable to most Australian households, even the less well off. We're talking about the cost of a burger and fries.”*⁶⁰

However, single health care expenses rarely occur in isolation as when people get sick they tend to require more than one form of care⁶¹. When combined with other independently-occurring increases in health care costs, such as fee increases from GPs, higher costs imposed by State Governments for home assistance and higher private health insurance premiums, along with other direct and indirect costs of illness (such as forgone income) the compounding effect of these increases can place a significant burden on individuals and families.

The risk in this situation is that introducing a GP co-payment could further discourage appropriate use of services and lead to a reduction in cost-effective, preventive care being provided. The effective prevention and management of chronic illnesses such as diabetes 2 require increased contact with the health system (in particular among disadvantage groups), along with improvements in health literacy and self-management. This will not be assisted through increasing co-payments.

Another major disadvantage of introducing a co-payment for currently bulkbilled services is that it would introduce an additional level of complexity and expense. One of the major advantages of bulkbilling is its administrative simplicity. Introducing a \$5 co-payment would increase the cost of each transaction, in particular once safety-net measures based on use over a 12 month period are introduced.

Increased up-front payments would also present an additional access barrier for people who may have adequate incomes but are experiencing cash-flow problems. Given that periods of illness often coincide with reduced earning capacity and other additional expenses, high up-front costs for unexpected illnesses can impact adversely on people, even when rebates are provided at a later stage. This can lead to people delaying or failing to access the care they need, resulting in the development of more serious health problems (which are often more costly overall to the community).

⁶⁰ www.news.com.au, accessed 16 January 2014 <http://m.news.com.au/TheNation/pg/0/fi9158461.htm>

⁶¹ As discussed below, around 80% of GP consultations result in a prescription for medication

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Future policy options

The myth of a health funding crisis

Supporters of increasing co-payments within the Australian health system frequently argue that increased individual contributions are required in order to reduce our ‘unsustainable’ level of health funding.⁶² However, this argument is not supported by the evidence.

While Australians are spending more on health care than we did when Medicare was introduced in 1983, this fact is not often put in the context of the changes in Australia since this time. We are a much wealthier society than we were when Medicare was introduced and it makes sense that we would want to spend some of this increased wealth on health care. Increased health spending without a good understanding of why these costs are rising, and if this is consistent with our community expectations and values is difficult to justify. There is a need to understand that demand-reduction measures (such as co-payments) may risk reducing access to cost-effective care and thereby increasing health care costs over the long-term.

In understanding the impact of the trend of increasing costs, it is important to understand that research⁶³ has shown that even if health care expenditure were to rise from 10 per cent of GDP to 20 per cent of GDP between now and 2050, the remaining 80 per cent of GDP in 2050 would still be higher than 90 per cent of GDP in 2013 (unless economic growth slows to historically low levels). In other words, Australia could double the proportion of the national income spent on health care over the next 35 years and still be better off, in economic terms, than we are today.

It is also important to note that by shifting health care expenses from Government budgets to consumers, for example by increasing co-payments, the overall cost of health care to the community does not change even if there is a reduction in Government program budgets. In fact, shifting expenditure to consumers can actually increase overall costs if it requires a more complex system to administer or results in a less efficient allocation of resources. For example, the introduction of a \$5 co-payment for bulk billed GP services would require significant additional administration for general practices resulting in higher transaction costs compared to the administratively simple process of bulkbilling.

Rather than focus on the overall level of expenditure on health care and demand reduction measures, it is important to maximise the value for our expenditure and ensuring that it reflects consumer and community priorities. The focus should be around delivering the best health outcomes for Australians in the most efficient and effective ways.

Co-payments: policy challenges

Due to the nature of health care needs and the structure of the Australian health system, a better system of co-payments will need to overcome a number of policy challenges. These are outlined below:

Uneven demand across the population: the use of health care among the population is uneven. This means that data on ‘average’ health service utilisation and costs is largely irrelevant when developing public policies in this area. People tend to be either sick or well, those who are mostly well spend very little on health care and those who are sick spend a lot.

⁶² For example, Barnes 2013

⁶³ Doggett J and McAuley Ian 2013

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In practical terms, this means that policies on co-payments should focus on areas where the bulk of health spending occurs, not on a largely mythical ‘average’ consumer. Co-payment policies which are based on ‘average’ patterns of health service utilisation and expenditure will end up with the healthy and wealthy paying contributing much less towards their care than the sick and the poor.

Unpredictability: health care needs are often unpredictable. People do not plan to get sick or have an accident. This makes it difficult to budget for possible health care expenses in the same way that people can budget for other household expenses. An efficient co-payment system needs to accommodate the unpredictability of health care needs.

Uneven demand over the lifespan: health care needs vary widely over a lifetime. People typically use the most health care when they are very young, very old and (for women) around the period of pregnancy and childbirth. These periods are often those when people have the least ability to afford to pay for health care. Increased co-payments for health care services during these periods are therefore more likely to create cost barriers to access.

A mixed public and private system: Australia has a mixed public/private health system with responsibility for funding and service delivery split between Federal and State/Territory governments and multiple private providers. Governments cannot control the fees set by private providers, such as GPs. This complexity needs to be accommodated within an approach to co-payments, without resulting in unnecessary complications for consumers.

GP services are only one component of primary health care: While consumers may not incur a direct cost for a bulkbilled GP service, bulkbilling alone does not result in free primary health care. That is because in the majority of cases, a GP consultation is only one component of the care required to treat a health problem. For example, the vast majority (around 80%) of GP visits result in a prescription which almost always requires a co-payment to fill.⁶⁴ There are also frequently referrals for further tests, allied health and specialist appointments. Often a return visit is required to assess progress and/or discuss the outcomes of the tests. These are not independent services occurring in isolation – they are all component of the same episode of care and their financial impact should be seen as a whole.

In addition to these costs, many people face additional direct and indirect costs when they have to access GP services. These may include: parking fees; forgone wages for taking time off work; and additional childcare expenses. These costs can be considerable. A survey by the Chronic Illness Alliance found that parking costs at hospitals presented a barrier to people accessing care:

We asked people if increased costs of hospital car parking had had an impact on their overall healthcare. Of the 213 who answered this question 49 (23) had missed an appointment, while 20 (9%) had gone without medicines in order to pay for parking, 47 (22%) had used alternative transport and 21 (10%) had changed doctors or hospitals. However the 152 (71%) had saved on other household items in order to afford the parking.⁶⁵

Any co-payment for bulk billed GP consultations needs to be seen in the context of all the other costs incurred by individuals and families when accessing primary health care.

⁶⁴ BEACH data shows that there 83 prescriptions issued per 100 GP ‘encounters’.

⁶⁵ Chronic Illness Alliance 2013

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Counter-intuitive consumer behaviour: There is a wide range of evidence from behavioural economics⁶⁶ that demonstrates that when it comes to health care, consumers often act completely contrary to the predictions of classical economists. For example, paying for people to donate blood has been shown to reduce, rather than increase, the level of donation. Other research from the public health and welfare sector has found that standard financial incentives that increase motivation in the commercial sphere may actually crowd-out intrinsic motivation for socially beneficial tasks.⁶⁷

Limitations of the research and data gaps

While there is a broad range of research available on co-payments for health care, there are also a number of limitations to this research and gaps in the available data. It is important that these gaps and limitations are taken into account when assessing the implications of the available research for developing policies on co-payments within the Australian health system.

One major limitation to the available research is that the majority of peer-reviewed studies in this area have been conducted in the USA. Often these studies are based on a specific population (typically patients enrolled with an individual health insurance provider such as a Health Maintenance Organisation). Therefore, their generalizability across the entire USA population is questionable and their applicability to the Australian context even more limited.

The majority of research on health care co-payments has been conducted in the pharmaceutical area and focusses on the impact of co-payments on the use of medicines (rather than other forms of health care such as medical or allied health services). Almost all the available research focusses on consumer behaviour, with only very limited research into the impact of co-payments on provider behaviour.

Other limitations in the research are that studies tend to focus on a single drug or health condition and on a single cohort of patients during a limited timeframe. This means that they provide little or no information about how co-payments affect access to health care and/or health status over longer periods of time. They also do not provide information about any potential hardships experienced by consumers as a result of co-payments, such as forgoing other essential goods and services.

Similarly, research studies on co-payments typically do not include those users who are excluded from care and/or people who did not even attempt to access care because of co-payments. Therefore, any impact on this group of people is not apparent from the research, despite the fact that they are likely to be the poorest and most marginalised members of society and therefore potentially the most vulnerable to co-payment increases.

Most importantly, there is very little robust research on the impact of co-payments on the longer term health outcomes of consumers. This makes it very difficult to draw any conclusions about the overall impact of co-payments on health status as the relationship between access to health care, the provision of care and health outcomes is very complex. Given the importance of this indicator this is a significant limitation in the research into this issue.

⁶⁶ For example, see Bowles 2009

⁶⁷ Ashra et al

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However, despite these limitations the research does provide consistent support for the view that co-payments act to decrease access to health services and that this impact is stronger in vulnerable groups, including people from low socio-economic groups, older people and those with chronic illnesses. As discussed above, these findings are supported by additional Australian-based research and the outcomes of extensive consumer consultations on this issue. Addressing these research gaps and limitations is essential in order to support effective and evidence-based policies on co-payments within the Australian health system. Specific data and research gaps that need to be addressed include:

- Data on current expenditure for health goods and services, with a specific focus on individuals and families living with chronic illness and disability
- Data on the broader costs associated with illness and disability
- Information on the impact of health care costs on specific groups in the community, including people with chronic conditions, people on low incomes and people in rural and remote areas
- Information on community and consumer values and preferences for health funding
- Data on consumers who do not access health care due to cost and other barriers
- Modelling in the Australian context about the impact of co-payments on usage, in particular among people with chronic conditions and disadvantaged groups
- Modelling in the Australian context about the impact of co-payments on provider behaviour, for example, how increased co-payments may impact upon privately set fees for health care
- Research into the overall cost impact of increasing co-payments (i.e. the cost over time to the community, not just the short-term cost to Governments)
- Research into the impact of increased co-payments in one sector on overall health service utilisation (i.e. whether increased co-payments for primary care result in increased demand for hospital services)

Until these data and research gaps are addressed, the introduction of any new co-payments (or significant increases in existing co-payments) risks a number of adverse impacts, including:

- increased hospital utilisation
- increased overall health care costs
- decreased equity of access to health care
- decreased overall efficiency of the health system
- decreased health status among vulnerable groups
- increased administrative costs

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The need for a community debate

Currently, co-payments for health goods and services are set independently without a coherent and integrated approach across sectors. As there has been no comprehensive consumer or community consultation on co-payments, health care providers, governments and health service managers make decisions about co-payment levels without an accurate understanding of community values and preferences for how health care is funded.⁶⁸

The ad hoc approach to consumer co-payments within our current health system reflects a lack of agreement by governments, health policy makers and managers on their purpose. There are no underlying principles which guide the implementation of co-payments for health care and no overall policy framework within which individual health care providers and services develop their own co-payment systems. Without a shared understanding and coherent policy on co-payments across all levels of government and all forms of health care, the current piecemeal approach will continue to create inefficiencies, distortions, unnecessary complexities and inequities in access to health care among consumers.

This can only occur in the context of a community debate on the fundamental principles underlying our health system. The starting point for this debate should be an acknowledgement that ultimately all health funding comes from consumers, regardless of whether it is administered at a federal or state/territory level or via public or private insurance. The debate should then focus on how a balance between individual and shared funding for health care can be determined which reflects community priorities and values.

On this basis, a specific policy on co-payments can be developed which would clarify the specific goals of co-payments, including whether they are designed to:

- raise more money for health care (if so, is this more efficient and equitable than alternative methods of raising health revenue, such as taxation?)
- reduce unnecessary consumption of health services? (if so, are we also reducing necessary consumption? Are there better ways to achieve this result?)
- reduce overall expenditure on health care? (if so, is this a good thing?)
- reduce the Government's expenditure on health care? (if so, are we just shifting costs elsewhere, for example to consumers?)

Due to the complexity of the Australian health system and its public/private mix of services and multiple stakeholders, it may not be possible to develop an agreed approach to all aspects of co-payment policy. However, a consensus on set of underlying principles for co-payments, informed by a broader community debate on health care funding, would be a positive start to the development of a coherent, consistent and consumer-focussed approach to co-payments across the Australian health system.

⁶⁸ Although when informed consumer debate on health resources use takes place, for example, in the context of a citizens' jury, the results suggest that consumers' priorities for funding differ markedly from those reflected by our current health system. (ACT Health 2010)

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A single safety-net

Fundamental to improving Australia's approach to co-payments is the need for a single, unified safety-net for all health care expenses. Currently, it is impossible to accurately target people who are unable to afford their health care costs. Existing safety-nets capture large numbers of people who have high short-term expenses but whose costs are not excessive over the longer term. They also miss important groups of consumers who have ongoing problems meeting the costs of their care, such as those who rely on non-medical forms of care or who use non-prescription pharmaceuticals and medical devices.

To address this issue, a single safety-net should be established to cover all current health care safety-nets, such as the PBS and Medicare safety-net and the Medicare tax off-set. This would go a long way to reducing the complexity and inefficiencies of the current system. Once these safety-nets have been linked together, other forms of health care including dental services, non-prescription medicines, medical devices and allied health services, could be added.

Primary care reform

While the efficiency of general practice and primary care have significantly improved over the past two decades there remain areas of potential improvement, particularly in the areas of workforce practices and remuneration. Overall, Australia uses GPs to do work that could safely and more efficiently be done by nurses and other health professionals. For example, Australia is one of the few countries in the world where GPs give routine immunisations.

There is a robust body of evidence supporting the potential for a broader role for nurses in primary health care and chronic disease management. However, research also demonstrates that the Medicare Benefits Schedule (MBS) is too complex and rigid to allow the best use of nurses' skills⁶⁹. This is because MBS funding for nurses is restricted to a small number of specific services, which limits the ability of practices to maximise and individualise their various talents.

Another barrier to effective chronic disease management within primary health care is the current fee-for-service funding system. This has been widely criticised by primary health care experts and stakeholders as not supporting optimum chronic disease management, even with targeted incentive payments.⁷⁰ This is largely because the fee-for-service system has difficulty supporting GPs and other team members to allocate sufficient time for comprehensive management of chronic and complex conditions, conduct health promotion and illness prevention activities, use team care approaches in specific patient groups and undertake population health planning.

A number of studies⁷¹ conducted on alternative funding systems for primary health care have concluded that capitation models, with salaried doctors, are the most effective in promoting comprehensive and cost-effective primary health care. The potential for this funding model to increase the efficiency and consumer-focus of our primary health care sector needs further investigation and research.

⁶⁹ McDonald et al 2008

⁷⁰ Douglas et al 2009

⁷¹ Young et al 2008

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Linking co-payments to value

In order for co-payments to support the efficient use of health care resources there needs to be a connection between co-payments and the value of health goods and services. This is not the case within our health system where there is no direct relationship between the level or type of co-payment required (and hence the level of subsidy) for a health good or services and the value of that service or good to individuals or to the community as a whole. Low-cost preventive health services (such as basic dental care) often cost more for consumers to access than higher cost acute care services (such as public hospital treatment). There are also a number of high cost services which have been shown to have little or no value.⁷² This can lead to consumers choosing more expensive forms of health care, thus increasing the overall cost of health care to the community as well as reducing individual health and well-being. In practice it is difficult to structure co-payments in a way that encourages consumers to access preventive care while not creating barriers to higher cost care to vulnerable groups in the community.

Linking co-payments directly with the value involves setting co-payment amounts based on the “value”, and not just the “cost” of the therapy.⁷³ This approach would require more comprehensive data than is currently available. However, as additional research into the costs and benefits of different forms of health care takes place, the findings should be used to inform co-payment policy so that over the long-term individual co-payments can more closely reflect value. In the short-term, significant improvements can be made by supporting consumers to choose forms of health care which (in general) are the most cost-effective. A number of policy options for achieving this outcome are outlined below.

Support the most effective and efficient care option: Co-payments should provide incentives for consumers to choose the most cost-effective health care option for their condition and avoid perverse incentives for choosing less effective forms of care. For example, preventive care should incur little or no costs and be made as accessible as possible to all in the community. This includes services such as immunisations, preventive dental care and screening for chronic disease risk factors.

The above options should be considered by Government in preference to adding additional co-payments onto an already inefficient and inequitable system.

Managing inappropriate demand

While there is no widespread evidence of inappropriate demand for primary health care within our current system, if practitioners feel that this is a problem in their practices there are a range of alternative policy options to increasing co-payments that do not have the potential to decrease access for groups of consumers. These techniques focus on improved management at the practice level which can maximise the use of GPs’ valuable time through triaging patients and using practice nurses, nurse practitioners and other members of the primary health care team to see people with less serious conditions. Primary health care and general practitioner organisations such as Medicare Locals and the Royal Australian College of General Practitioners provide training and resources to GPs to improve their practice management.

⁷² Elshaug 2013

⁷³ See Spaulding et al., 2009 for a more extensive discussion of this issue

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At a broader level, where there is evidence of widespread over-use of specific forms of health care, such as anti-biotics, public health campaigns can reduce demand by educating consumers and practitioners about appropriate use.⁷⁴

Conclusion

Co-payments play an important role within the Australian health system and directly impact upon consumers' access to health care. However, they have received little policy attention and, as a result, Australia's current 'system' of co-payments is not meeting the community's need for an efficient and equitable funding system.

The relationship between co-payments, utilisation of health care and health outcomes is complex and it is difficult to know exactly how co-payments will impact upon different groups of consumers in the Australian context. However, there is good evidence that overall co-payments reduce access to both inappropriate and necessary care and that there is no evidence that they reduce overall health care costs. Therefore, there is a risk that the introduction of additional co-payments for bulkbilled and hospital emergency department visits could adversely impact upon the health of some already marginalised groups in the community and result in an overall increase in costs to the community.

Improving the role of co-payments for health goods and services cannot occur in isolation but should be part of a broader debate over the future of Medicare and funding arrangements for health care more generally. Australia has changed significantly since the fundamental structure of our health funding system was established by the introduction of Medicare in 1983. Our health care needs are focussed much more on the prevention and management of chronic disease than on the short-term treatment of acute conditions. We are also a wealthier society overall, although with greater divisions between the most advantaged and the least well-off. The health system has also evolved during this time with a greater fluidity between the settings in which care can be provided (for example hospital in the home and ageing-in-place). Allied health and alternative health modalities are playing a more significant role in the treatment of illnesses and disabilities for many consumers today, compared with a generation ago.

Given these changes, it is reasonable that changes may need to be made to the way in which we fund health care in Australia. However, in order to ensure any changes reflect consumer values and priorities they should be transparent and occur in the context of a community debate. Current proposals to increase individual co-payments are a piecemeal and ad hoc approach to health funding which does not take into account their context or overall impact on consumers, particularly those in vulnerable groups. However, changes made in partnership with consumers and other stakeholders and based on genuine and comprehensive community consultation and robust research provide a valuable opportunity to improve our current funding arrangements and equip our health system to meet the challenges of the future.

⁷⁴ For example, the National Prescribing Service's 'Common colds need common sense' campaign <http://www.nps.org.au/publications/consumer/medicines-talk/pre-2007/mt10/common-colds-need-common-sense2>

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The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF does this by:

1. advocating for appropriate and equitable healthcare
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated healthcare system that values the consumer experience
- prevention and early intervention
- collaborative integrated healthcare
- working in partnership

CHF member organisations reach Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.