The Australia Institute
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Submission to the Senate inquiry into out-of-pocket costs in Australian healthcare

Submission
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Introduction

The Australia Institute is pleased to make a submission to the Community Affairs References Committee's inquiry into out-of-pocket costs in Australian healthcare.

This submission will address the following points of the Inquiry's terms of reference: the trend in out-of-pocket expenses; the impact of co-payments; key areas of expenditure including primary care visits, pharmaceuticals and diagnostic testing; the role of private health insurance; the effectiveness of safety nets; and other options to achieve savings for Australians and the government.

Background

Australia has had a system of publically funded universal health insurance since 1984. Medicare aims to provide 'fair and affordable' access to medical services for all Australians. Complementing this system is the Pharmaceutical Benefits Scheme (PBS), enacted in 1953, which subsidises prescription medications. However, out-of-pocket expenses are reducing access to 'fair and affordable' healthcare.

Age and social disadvantage are key determinants of poor health.[1] While an individual's health needs generally increase as they age, social disadvantage is associated with poorer health at all ages. In some cases levels of social disadvantage can mean visits to the doctor are postponed or avoided; prescriptions for medicine are not filled or delayed. The same is likely to be true for referrals to diagnostic testing where it is unknown what costs may be incurred.

In addition to age and social disadvantage, women also face a higher burden from gap fees. Up until retirement age women visit the doctor more frequently than do men of an equivalent age.[2] ABS data show that women made more visits (23 per cent) to the doctor during the two week survey period than men (18 per cent).[3]

Trend in out-of-pocket expenses

The trend in out-of-pocket expenses tells a mixed story. The extra cost faced by people needing to visit the doctor since the introduction of Medicare resembles a roller coaster. Following initial improvements and a steady increase in bulk billing only two out of ten visits were incurring out-of-pocket expenses (also known as gap fees) by 1996-97. However, this achievement in delivering 'fair and affordable' healthcare for a majority of Australians turned around with increasing numbers of people charged gap fees by their doctor. By 2003-04 there had been a twelve percentage point increase in bulk billing rates returning to levels previously seen in 1989-90. Although the proportion of patients charged gap fees have since returned at a similar rate back to two out of ten (2012-13). However, the bulk-billing rate will effectively cease to exist for many Australians should the federal government decide to introduce a co-payment on visits to the doctor.

Medications listed on the PBS are subsidised by the Commonwealth, with the public required to make a capped co-payment. The maximum co-payment paid by individuals is currently $36.10 per prescription (though not all medications reach this cost threshold) with concession card holders paying $5.90 per item. Where a medication comes under the co-payment threshold some Australians are paying more than others due to the charging of brand premiums.

[1] AIHW, (2012), *Australia's health 2012*.

[2] Parslow et al, (2004), 'Gender differences in factors affecting use of health services: an analysis of a community study of middle-aged and older Australians'.

[3] ABS, (2012), *Australian Health Survey: Health Service Usage and Health Related Actions*.

The rate of bulk billing for pathology tests is higher than bulk billing for GP visits. This incongruity suggests that some GPs are willing to charge gap fees for their own services yet are happy to request that their patients are bulk billed for the pathology tests to which they refer them. The likelihood of being charged a gap fee for imaging is twice that for pathology. In 2012-13 there were 21.4 million Medicare imaging tests.[4] A quarter of patients faced out-of-pocket charges for these tests. While there has been a steady improvement in the fairness and affordability of pathology services, in part due to regular reforms and changes by the government the same is not true for imaging tests. In 1998-99 the rate at which gap fees were charged for imaging began to increase against trend, peaking at 42 per cent in 2003-04. Although the levying of gap fees for imaging began to decline after this peak the earlier relationship with rates of out-of-pocket expenses for pathology was not achieved until 2009-10.

Negative impact of co-payments

The Australian Bureau of Statistics (ABS) has previously reported data on the negative impact of costs on access to health services. This survey was conducted in 2008, however, and in light of this Inquiry and the ongoing pressure on households from out-of-pocket expenses the Committee should recommend the ABS update this survey before any decisions such as the charging of a standard co-payment for visits to the GP are introduced.

In 2008 more than one million Australians aged 15 and over delayed seeing a GP due to the cost of the consultation (ABS, 2010). People aged less than 45 years were more likely to put off making an appointment. When Australians are forced to make health decisions based on how much it will cost it is evident that Medicare is not achieving the promise of affordable healthcare. The Australian Medical Association (AMA) has stated that the proposal for a standard co-payment of $6 for visits to the doctor (albeit with 12 exempt visits for families) would likely increase the number of Australians delaying visits to the doctor.[5]

Further costs are faced by patients (11.3 million in 2009) who leave the doctor's surgery with a prescription for medication.[6] The cost of medication can deter some patients from having their prescriptions filled at all.[7] It has been reported that a third of Australians perceive the cost of prescription medications to be a 'moderate to extreme' burden.[8] ABS data show that in 2008 almost one in ten people delayed purchasing or did not purchase the medication they had been prescribed because of the cost.[9]

Similarly, the cost implications of diagnostic testing for the patient can be substantial. A 2001 study found that more than 15 per cent of Australians (an estimated 2.18 million people) did not undergo a recommended test, treatment or follow-up during the previous year due to the cost of that procedure.[10]

Out-of-pocket expenses in key areas of health services

The negative impact that charging out-of-pocket expenses has on access to health services can be given dollar values based on available data.

[4] Department of Health, (2013a), *Annual Medicare Statistics* (website).

[5] ABC, (2013), 'Australian Medical Association criticizes proposal for up-front general practitioner fee'.

[6] ABS, (2010), *Health services: patient experiences in Australia 2009*.

[7] NPS, (2007), *NPS News 55: Generic medicines: dealing with multiple brands*.

[8] Searles et al, (2007), 'Reference pricing, generic drugs and proposed changes to the Pharmaceutical Benefits Scheme'.

[9] ABS, (2010).

[10] Blendon et al, (2002), 'Inequities in Healthcare: a five-country survey'.

Primary care visits

In 2012-13 the average gap fee paid for out of hospital GP visits (non-referred GP attendances) was $28.58 per visit. There were more than 115 million such visits of which approximately 21.7 million visits resulted in gap fees being levied.[11] Using the average out-of-pocket expense it can be calculated that Australians paid $615.9 million in gap fees for GP visits in 2012-13. The burden of out-of-pocket expenses is likely to be shouldered more by the aged, lower socio-economic groups and women as they are more likely to see the doctor.

Pharmaceuticals

Published data from 2009-10 shows that 16.7 million prescriptions where dispensed with a brand premium.[12] The average brand premium payable for PBS listed medications was $3.72.[13] Therefore, it can be estimated that the charging of brand premiums added approximately $62.1 million to the healthcare costs of Australians. The extra cost of brand premiums can be avoided by requesting a generic option for the prescribed medicine. But even this does not guarantee the full cost of brand premiums will be avoided as prices vary between pharmacies. For example, the cost for the common antibiotic Amoxycillin[14] ranged between $6.50 for a generic brand and $12.00 for the branded Amoxil option.[15] The average price reported by the PBS was $10.77. In the financial year 2009-10 there were 2.4 million units of this medication dispensed[16] which adds up to $25.8 million. If every prescription for Amoxycillin had been filled with a generic option costing $6.50, Australians would have saved $10.2 million.

Diagnostic testing

While GPs are upfront about the amount they will charge and extra costs for prescription medicine is hidden from the customer patients referred for diagnostic testing often do not know what gap fee they may face if any. This uncertainty is likely contributing to the delaying of tests by some Australians. Indeed, one report found '[c]onsumers wanted informed financial consent before accessing medical imaging'.[17] Evidently some Australians are unhappy with the uncertainty around the charging of out-of-pocket fees for diagnostic testing.

Pathology

Those patients who are not bulk billed for pathology tests face sizable gap fees. The AMA recommend charge rate for pathology services are almost twice the rebate provided by Medicare.[18] In 2010, gap fees charged for pathology services were reported to range from $50 up to $190. Medicare statistics report that there were 120.6 million pathology services in 2012-13, of which more than 2.7 million incurred gap fees.[19] Therefore, the estimated value of gap fees paid lies somewhere between $136.9 million and $520 million.

Imaging

The peak body for private providers of diagnostic imaging, the Australian Diagnostic Imaging Association (ADIA), reported in 2010 that the average gap fee for medical imaging was $66.

[11] Department of Health, (2013a).

[12] PBPA, (2010), *Annual Report: for the year ended 30 June 2010*.

[13] Department of Health, (2013b), *Browse by Price Premium* (website).

[14] Amoxycillin was the 17th highest volume drug on the PBS in the financial year 2009-10.

[15] Fong, (2010), 'Discount medicines: Pharmacy price comparison'.

[16] PBS, (2010), *Expenditure and prescription twelve months to 30 June 2010*.

[17] CHF, (2010), *Quality Use of Medical imaging: Final report*.

[18] Bray, (2010), 'Pathology gap fees'.

[19] Department of Health, (2013a).

More recently the ADIA noted that the gap fee patients pay is "increasing at approximately 10 per cent per annum".[20] On this basis, three years later the average gap fee is likely to be in the vicinity of $88. Based on these figures, it can be estimated that $471 million in gap fees were levied in 2012-13 for imaging tests.

Australians paid an estimated $1.3 billion to $1.7 billion in out-of-pocket expenses in 2012-13. This burden and the associated negative impact this has on postponed or avoided primary healthcare is undermining the health of many individuals and increasing the risk of larger, longer term costs for the Commonwealth health budget through the potential for greater health issues due to missed primary healthcare.

Private health insurance

There are limitations placed on private health insurance for covering out-of-pocket expenses for primary healthcare. The reason for this is the recognised likelihood, by many including successive federal governments, that such coverage would result in a ballooning, if not sky rocketing in the amount doctors et cetera charged for health services. While those who can afford private health insurance would be able to offset some of this increased cost, (depending on their level of coverage) such a step, as has been proposed recently would increase the cost of primary health services and inequality of access to these services as more and more Australians would be likely to delay seeing the doctor. The evidence presented so far in this submission highlights the already existing burden of out-of-pocket expenses and any further price pressure would only increase this burden. The scale of increases in out-of-pocket expenses is something the Committee should recommend Treasury model before any such decision is made.

Safety nets

Safety net policies are intended to help with the cost of healthcare for Australians with high needs not as coverage for out-of-pocket expenses. Once a threshold is reached an increased rebate for subsequent medical costs and reduced co-payments for prescription medicines are paid. In terms of the Medicare safety net it is important to note that only scheduled fees count toward the threshold, any out-pf-pocket expenses do not count. However, once the threshold is passed 80 per cent on the latter are reimbursed. Similarly, extra costs paid by Australians in the form of brand premiums are excluded when calculating eligibility for the safety net. The rationale for this is similar to the restrictions placed on private health insurance to provide coverage for gap fees. Any offsetting of out-of-pocket expenses would encourage the charging of higher gap fees which would exacerbate the negative impact of these expenses, especially for those least able to afford it who are also more likely to need primary healthcare.

The two safety nets operate differently. While the Medicare safety net registers all scheduled costs toward the threshold (family members are required to notify Medicare to so that costs are combined) for costs to be registered for the PBS safety net an individual or pharmacists is required to keep a record. The Auditor-General reported in 2010 that up to 144,000 people who were eligible for the PBS safety net in 2007 did not apply and as a result missed out on accumulated savings estimated to be as much as $10.8 million. The government has acknowledged that individuals are missing out on the intended benefits of safety net polices because they have neither enough information about either their eligibility to apply for them nor a clear understanding of how to keep the required records.[21] The committee should recommend the PBS safety net is improved to match the recording of incurred costs as is presently the case with the Medicare safety net.

[20] ADIA, (2013), *Medical imaging can end chronic pain – if you can afford it*.

[21] ANAO, (2010), *Medicare Australia's Administration of the Pharmaceutical Benefits Scheme*.

Opportunities for reforms and savings to the health budget

There are opportunities to reform aspects of primary health services that would, for most Australians go unnoticed instead of making changes that would add to the existing burden of out-of-pocket expenses. Two such reforms are briefly outlined below.

Pharmaceuticals

An increase in the proportion of prescriptions filled with generic medicines and associated savings for Australians could be readily facilitated by changing the settings on prescribing programs used by doctors. There is a precedent for making such a change.

In 2008 the National Health (Pharmaceutical Benefits) Regulations were changed to prohibit a default setting in computerised prescription software that checked the "no brand substitution" box on prescriptions.[22] A study published in *The Medical Journal of Australia* found this amendment reduced from 27 per cent down to one per cent the number of prescriptions for antibiotics in which the "no brand substitution" box was checked.[23]

Many of the computer programs used by doctors for writing prescriptions have an 'equivalency' function which lists all medication options that contain a specific active ingredient. Regulation that required a default setting that uses the active ingredient – except where the "no brand substitution" box is marked – would be likely to achieve similar success to the regulated changes to default settings for brand selection. Automatically prescribing medications by their active ingredient would reduce reliance on consumer awareness of generics and incentive payments to pharmacists with cost savings for individuals and the government.

The Committee should recommend that software used to write prescriptions for pharmaceuticals are required to prescribe by active ingredient rather that by brand name except where the "no brand substitution" box is marked.

Diagnostic testing

GPs use referral forms to order diagnostic tests for their patients in the same way they use prescription forms to prescribe medications. Unlike prescription forms, however, referral forms are often branded, effectively directing patients to a particular service provider. In most cases this is to a private service provider who may charge out-of-pocket expenses and not a public provider which will not.

The influence of branded referral stationary has been partially addressed by legislative amendments passed in 2010 that allows a patient to take a referral to any provider. Prior to this act, referring GPs were required to specify a pathologist in a referral request – a requirement conveniently met with branded forms. With this change there is less reason to persist with the permitted use of branded referral forms. The Committee should recommend that standard referral forms be used for diagnostic testing in the same way that standard prescription forms are already used.

Conclusion

Additional costs are faced by Australians each time out-of-pocket expenses are charged or a brand premium is paid for medication when cheaper generic options are available. Australians paid an estimated $1.3 billion to $1.7 billion in out of pocket expenses for GP

[22] This box is available for doctors to check if they believe that changing the colour or shape of a medication may cause confusion for the patient.

[23] Newby and Robertson, (2010), 'Computerised prescribing: assessing the impact on prescriptions repeats and in generic substitution of some commonly used antibiotics'.

visits, brand premiums on medications and diagnostic testing in 2012-13. This expense will rise noticeably if the government introduces a co-payment for visits to the doctor.

This submission identifies operational and procedural changes that could be acted on immediately with positive outcomes for the health budget of households and a reduction in the burden of out-of-pocket expenses.

The Australia Institute asks the Committee to consider recommending that:

- the ABS update this survey before any decisions such as the charging of a standard co-payment for visits to the GP are introduced
- Treasury model the impact on out-of-pocket expenses in the hypothetical scenario that private health insurance was to be permitted to offer coverage for out-of-pocket expenses for primary healthcare
- the PBS safety net is improved to match the recording of incurred costs as is presently the case with the Medicare safety net
- software used to write prescriptions for pharmaceuticals are required to prescribe by active ingredient rather that by brand name except where the “no brand substitution” box is marked
- standard referral forms are used for diagnostic testing in the same way that standard prescription forms are already used.

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