Out-of-pocket costs of health care in Australia
Submission to the Senate Standing Committee on Community Affairs

Prepared by

Beverley Essue¹,³, Tim Usherwood¹,², Tracey Laba³, Stephen Leeder¹,
Farhat Yusuf¹, James Gillespie¹, Vlado Perkovic³, Andrew Wilson¹, Stephen Jan¹,³

¹ The Menzies Centre for Health Policy, University of Sydney
² Discipline of General Practice, University of Sydney
³ The George Institute for Global Health
Current and future trends in out-of-pocket expenditure by Australian health consumers

Out-of-pocket expenses (even excluding the cost of private health insurance premiums) comprise approximately 18% of health spending in Australia – a higher proportion than in most OECD countries and higher than the OECD median of 15.8% (2). In a comparison across 14 OECD countries, only residents of Switzerland and the United States pay more dollars out-of-pocket for their health care (3).

Any claims that our current health system has to equity and fairness are undermined by the large number of individuals and households who face the prospect of economic hardship and reduced access to treatment resulting from the out-of-pocket costs of health care. Almost half of total spending on medications comes out of consumers’ pockets as does 60% of spending on dental care (2).

There is growing evidence that describes the household economic burden in Australia of chronic and long-term illnesses, with out-of-pocket costs being a major component. For example, a recent study reported that of people living with advanced chronic obstructive pulmonary disease, 78% experienced economic hardship from managing their illness and 27% were unable to pay their medical and dental expenses (4). Respondents experiencing economic hardship had higher out-of-pocket illness-management costs overall, and for medications and oxygen specifically.

This heavy burden of out-of-pocket costs has also been demonstrated in other common chronic conditions, including cancer (5), stroke (6), kidney disease (1) and end of life care (7). People with five or more chronic conditions spend on average five times as much on their health as those with no diagnosed chronic conditions. Each additional chronic disease adds 46% to the likelihood of a person facing severe financial difficulties due to health costs (8).

Collectively, these studies demonstrate that the individual contributions that are required of people with chronic illness can be prohibitive, consuming a substantial share of a household’s available resources, particularly for those who are already economically disadvantaged (9).

Impact of co-payments on health care access, outcomes and costs

Out-of-pocket costs have a direct impact on access to health care. In 2013, 14% of Australian adults reported that they did not attend the doctor and/or did not get recommended care because of cost. Amongst those living with chronic health problems, this proportion was 24% (10).

People with five or more chronic conditions spend on average five times as much on their health as those with no diagnosed chronic conditions.
A recent review of the international evidence on the effects of copayments for consultations with general practitioners and with specialists found that copayments reduced demand for consultations, but that the reduction in use was highest by individuals with low income and ill health (11).

Approximately 10% of adults referred to a specialist delay or do not keep their appointment because of cost (12). Similarly, around 9% of adults delay or do not fill prescriptions for essential medications because they cannot afford to do so (12). This proportion rises to over 12% in the most socioeconomically disadvantaged fifth of the population (12).

In 2005, PBS copayments increased by over 20%. Following this, dispensing of medicines prescribed for diseases including epilepsy, glaucoma, Parkinson’s disease, asthma, osteoporosis, and thyroid deficiency significantly decreased. Additionally, dispensing of statins and some antiplatelet drugs decreased - these drugs are commonly used to prevent heart attacks, strokes and other vascular diseases (13). The decreases in dispensing of such essential medicines were greater for social security beneficiaries than for general PBS beneficiaries.

The attribution of the decrease in dispensing to the increase in PBS copayments is supported by a wide range of research internationally that consistently demonstrates reduced uptake of prescribed medications by publicly-insured consumers who face prescription copayments (14, 15). For Australia, the adverse effect of increased copayments on prescription medication use is not specific to those living in remote or disadvantaged areas; it is happening within all areas across the nation (16).

There are consequences from not obtaining prescribed medications because of unaffordable costs. For example, patients with high blood pressure who do not take their medication properly are almost twice as likely to be hospitalized as those who do (17). The majority of a cohort of General Practitioners surveyed in Western Sydney believed that at least some of their patients had experienced deterioration in health, had been admitted to hospital or had died as a consequence of not obtaining their prescribed medications because of cost (18). The quality use of medications by patients may also be compromised: anecdotal evidence from many GP colleagues report patients who split their tablets so as to take only one half at a time, or take their tablets on alternate days, to ease the cost burden of their prescriptions.

Effects of copayments on other parts of the health system, and implications for sustainability

Optimizing health, reducing morbidity and minimizing demands on hospital services requires timely access to out-of-hospital medical care, including general practitioners laboratory tests, including vital INR readings, routine blood tests for digoxin levels, diabetes, ECGs, heart scans, a mechanical valve, and a few check-ups on the pacemaker.

(Male in his late sixties with Chronic Heart Failure, Western Sydney, NSW) (30).
and medical specialists, and when necessary community nursing and/or allied health practitioners. Gap payments and PBS copayments not only reduce access, they impact most significantly on the poor – those who are most likely to suffer ill health in the first place. We found evidence of cost-related non-adherence in all of our studies with patients with chronic illness. Delaying or not attending medical appointments and skipping medications are routinely cited as strategies used by patients who are unable to afford the copayments associated with their care (1, 4, 6, 7, 19). The effect of reduced access and health care utilisation is inevitably reduced health outcomes, impaired prognosis and higher downstream healthcare costs.

Key areas of expenditure, including: pharmaceuticals, primary care visits, medical devices or supplies, and dental care

From the 2009 ABS Household Expenditure Survey, the mean out-of-pocket household expenditure on health care was $3585 and $3377 per annum for older and younger households respectively. However, when evaluated as a proportion of their total household budget, older households incurred much higher out-of-pocket expenditure (9.4%) than younger households (4.7%) (20). For younger households, private health insurance was the biggest expense. Younger households also spent substantially more on health practitioners’ fees but much less on both prescription and non-prescription medicines compared with older households. But these figures are from people with and without chronic disease.

For people with chronic disease, who are regular users of the health care system, the burden of out-of-pocket costs is more pronounced. Patients face copayments at various places in the system: GP and specialist appointments, medical and diagnostic tests, pathology tests. Recent studies in populations with chronic obstructive pulmonary disease and chronic kidney disease found patients spent up to between $600 - 1400 per three months out-of-pocket on medical services, medications, community services and transport (1, 4). While there are safety net programs in place to cap spending on Medicare-eligible out-of-hospital care and PBS-listed medicines, this research showed patients often struggle to pay out-of-pocket costs before reaching the set thresholds each year. In addition, the types of expenses they face (e.g. medical devices, over-the-counter medications, non-PBS listed drugs) fall outside the safety net programs so contribute substantially to their out-of-pocket burden.

Given this burden of out-of-pocket costs found in the general population and in particular, in those with chronic disease, there is an urgent need to review the role of out-of-pocket expenditure in the current system. Much of this expenditure results from copayments for care that is not rebated (e.g. by Medicare, private health insurance or other sources). We therefore support the recent recommendation made by the Consumer’s Health Forum to improve the current system by developing a national policy on copayments, informed by community consultation and the growing body of Australian research on this issue (19).

Recommendation 1: Develop a national policy on and underlying principles for the use of copayments in the Australian health care system.

There are three medications, taken from the pharmacy … it’s not just one kind of tablets but three kinds, and it’s very expensive. … There are times, I have to make a decision whether it’s medication, or food, or whatever, pay the bills and that, so and sometimes, we don’t have enough money, and then we rely on our children to make up the bills and that, and sometimes we don’t fit the medicines, one time we miss it until we get enough money, and then get it the next time.

(Migrant wife carer of a husband with complicated diabetes, Western Sydney NSW) (30).

I mention it to her [doctor], “we can’t buy the medicine that you prescribed, because we haven’t got money”, and she said well “I know, well that’s why [your] husband blood sugar level is high, because he’s not taking the tablets”, because I can’t buy them from the pharmacy, so … and we don’t have the card, the concession card that reduces the price of the medication, so what do we do?

(Migrant carer whose husband has diabetes, Western Sydney, NSW) (30).
Role of private health insurance

It is important to note that in Australia private health insurance is highly subsidized from public funds, directly through the private health insurance rebate, and indirectly through the subsidies of Medicare to doctors, pathology, radiology and pharmaceuticals. Public hospitals meet the costs of more than 80% of emergency medical care, regardless of private health insurance status.

Higher levels of private health insurance coverage cannot provide solutions to the cost burden of out-of-pocket expenses as currently constructed. In some ways it makes it worse. A recent study using ABS Household Expenditure data found that both younger and older households that had private health insurance spent about four times more on health care than those that did not have such cover. About half of this difference represented the cost of the insurance premiums (20).

While the proportion of services in private hospitals under ‘no-gap’ agreements has risen from 82 to almost 90% in the last decade, the average gap payment is over $190. There are large regional disparities. At the high end, in the ACT 22% of private hospital services had a gap: on the average consumers paid $306.46; in NSW the average gap payment is $239. In contrast, SA, with 94% of service ‘no-gap’, out-of-pocket payments averaged $81.61 (21).

There is a real risk that freeing up private health insurance to cover more of the gap in health care costs will actually make out-of-pocket expenses for those who cannot afford private health insurance worse as there will be no disincentive for doctor’s to limit the size of copayments. Moreover, this will have flow on effects for Commonwealth expenditure because more people will have out-of-pocket expenses that contribute to the safety net threshold. It is also likely to place upwards pressure on private health insurance premiums, with flow on consequences for Commonwealth health expenditure through the private health insurance rebate, already the fastest growing element of the Commonwealth health expenditure.

Recommendation 2: No further changes should be made to what private health insurance can fund in terms of gap and out-of-pocket expenses without a full analysis of the likely flow on effects to the uninsured.

Propriateness and effectiveness of safety nets and other offsets

It is striking that about 80% of general practice consultations but less than 30% of specialists’ appointments for clinic care are bulk-billed (22). The average gap between the private fee charged by a specialist and the Medicare benefit received by a patient is approximately $60, but gaps in excess of $100 or more are not uncommon.

Most private specialists do not bulk bill, and because the poor can’t afford to pay gap fees in the first place, less than 4% of Extended Medicare Safety Net benefits go to the 20% of the most socioeconomically disadvantaged members of our population: in contrast, over 50% of benefits are distributed to the 20% most advantaged (23). This is a policy failure – it is the poor who are most likely to suffer ill health, and who have the lowest discretionary income, and yet are least likely to benefit from the Extended Medicare Safety Net.

Nine Percent of adults delay or fail to fill prescriptions because they cannot afford to do so, but this percentage is over 12% in the most socioeconomically disadvantaged fifth of the population (12). Despite the reduced prescription copayment for concession cardholders, many economically disadvantaged members of the population: in contrast, over 50% of benefits are distributed to the 20% most advantaged (23). This is a policy failure – it is the poor who are most likely to suffer ill health, and who have the lowest discretionary income, and yet are least likely to benefit from the Extended Medicare Safety Net.

The [private health insurance] policy costs a lot of money and things still cost a lot with it, but the fund helps some

(Female in her late seventies with cancer, Melbourne, VIC) (7).
disadvantaged patients with chronic illness never reach the PBS safety net because they cannot afford the copayments on earlier prescriptions. In addition, much of their spending would not qualify them for either of the safety net programs (e.g. transport costs, non-PBS listed drugs), as discussed above. Furthermore, Australian research has shown that those on low incomes receiving general pharmaceutical subsidies (i.e. the working poor) face a substantial financial burden with low income households foregoing the equivalent of between 5-26% of their discretionary income for between seven and nine months of the year before receiving additional subsidies (16).

Individuals also face a number of challenges using the Medicare and PBS safety net programs. Patients report difficulties understanding the safety net requirements, are often unaware of their eligibility for these programs and are unaware of whether they have qualified for the safety net (7, 19). Other challenges include: the timing of the programs (i.e. eligibility is determined on a calendar year basis, meaning that individuals must re-qualify each year); complex application and administration processes (i.e. inconsistent application processes, requirements to keep track of your own spending, differing eligibility based on family or individual spending) and inequities in the programs (i.e. among older households, couples will qualify earlier than singles).

Recommendation 3: Review of the safety net programs and other offsets available in the system. Current social welfare programmes do not adequately accommodate for the impact of illness on economic well-being across various life stages and illness trajectories. Future programs will need to address the key drivers of out-of-pocket costs and have the flexibility to respond to changing circumstances.

Market drivers for costs in the Australian healthcare system

Access to private specialist services is determined largely by market forces. This is most apparent in the geographical maldistribution of the medical workforce, with relatively few specialists choosing to work outside metropolitan areas (24). Even in metropolitan areas, there is a tendency for private specialists to practice in affluent areas, limiting the choice available to patients in more deprived areas, whose mobility may be reduced by poverty or disability. Yet it is in socioeconomically deprived areas that patients are more likely to suffer multiple chronic illnesses.

There are no Medicare incentives for specialists to bulk-bill for consultations. General practitioners receive incentive payments for bulk-billing concession cardholders and children. A Medicare incentive for specialists to bulk-bill consultations and other services for concession card holders and children would help to address the financial barrier faced by many patients. Such an incentive would also help redress the potential differential in revenue for specialist

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We don’t have access to the safety net at the moment — it usually kicks in about June and finishes in December. The chemist bills are killing me at the moment.

(Caregiver of a man in his early sixties with cancer, out-of-pocket costs/3 months A$760, Melbourne, VIC) (7).

I walked in there [chemist] last time to get my Webster Packs for a month and I got an unexpected bill for $85 and that was hard. I’m on one or two over the counter medications and they’re not funded by Government.

(Male in his early sixties with CHF and diabetes) (30).
practices between affluent and deprived communities. A bulk-billing incentive would be more socially just than the current Extended Medicare Safety Net (25).

**Recommendation 4:** A Medicare incentive for specialists to bulk-bill consultations and other services for concession card holders and children would help to address the financial barrier faced by many patients.

**Other related matters**

We believe that a compulsory copayment for bulk-billed GP consultations, even if only $6, would exacerbate the financial barriers that economically disadvantaged Australians face in obtaining health care, further exacerbating inequities of access. Although some have argued that a ‘price signal’ will deter unnecessary consultations, there is little evidence to support this (26). This also presumes that consumers know the severity and prognosis of their condition before their consultation.

However evidence of the converse exists: eliminating cost-barriers in general practice is not associated with any increase in general practitioner consultations (27). Delayed diagnosis risks both harm and increased downstream healthcare costs. Importantly, every GP consultation is an opportunity for detecting asymptomatic disease, reducing risk, addressing unhealthy behaviour and promoting health (28); a copayment would reduce these opportunities with potential long-term impacts on both health and health care costs (29).

The national Closing the Gap (CTG) initiative includes two measures which directly reduce cost barriers to healthcare access for Indigenous Australians. The CTG PBS scheme reduces prescription copayments for enrolled Aboriginal or Torres Strait Islander patients who have a chronic disease or are at risk of chronic disease. Prescribers accessing this scheme for their patients report a marked increase in adherence to essential medications. The CTG Care Coordination and Supplementary Services (CCSS) scheme assists with the gap between specialist fees and the Medicare rebate; again, GPs report that Indigenous patients who would not previously have been able to afford essential specialist care are now able to do so.

We need financial/supportive help with medications and home help... The safety net goes up each year—come January we need to pay $33 [per prescription]. Can’t someone with terminal cancer get a healthcare card and help with payments?

*(Female in her late forties with cancer)* (7).

**Recommendation 5:** A compulsory copayment for bulk-billed GP consultations should be avoided. It will exacerbate the financial barriers that economically disadvantaged Australians face in obtaining health care and further exacerbate inequities of access.
References


