COTA
For older Australians

SUBMISSION TO THE SENATE INQUIRY INTO OUT-OF-POCKET COSTS IN AUSTRALIAN HEALTHCARE

Prepared by

National Policy Office

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COTA Australia

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INTRODUCTION

COTA Australia is the national policy vehicle of the eight State and Territory Councils on the Ageing (COTA) in NSW, Queensland, Tasmania, South Australia, Victoria, Western Australia, ACT and the Northern Territory.

COTA Australia has a focus on national policy issues from the perspective of older people as citizens and consumers and it seeks to promote, improve and protect the circumstances and wellbeing of older people in Australia. Our submissions always incorporate the views of our members developed through various consultation mechanisms.

COTA welcomes the Community Affairs References Committee's inquiry into out-of-pocket costs in Australian healthcare. This comes up from our membership and older people more generally as a key area of concern. For the last federal election we convened an election panel or around 900 older people and access to affordable and quality health care came up as the number one area of concern.

Since the media discussion on Medicare and PBS co-payments started we have had a steady stream of people contacting us with details of their out of pocket expenses and what these payments have meant to them in terms of access to healthcare, and to their more general quality of life. It is clear that many people are fearful of any increase in out of pocket expenses through co-payments, or reductions in the level of subsidy for MBS and PBS.

This submission will provide comment on how the trend in out of pocket costs is already affecting older people's ability to access health care, concerns regarding the current proposal to increase these costs, and our recommendations for addressing the ongoing sustainability of the health care system.

ISSUES

Trends in out of pocket expenses

Out of pocket expenses for medical services have risen significantly with nearly 20 per cent of health costs now coming from individuals' own resources. This does not include private health insurance premiums or taxes. This means that on average all Australians pay more than $1000 per year out of their own pockets to access health care. For people with children or those with multiple and chronic conditions the amount paid could be considerably more.

As reported in the Mend Medicare Report[i] the average out-of-pocket cost for a visit to non-bulk-billing doctors in 2012 was $46.50, up from about $30 five years previously; and the average family is paying several thousand dollars out of their own pockets each year to access health care - increasing by over 6 per cent a year for the last decade.

Another recent report[ii] reveals that, in Australia, individual co-payments comprise 17% of all total health care expenditure, higher than most other OECD countries. This report confirms

that these existing co-payments are causing financial hardship for many consumers, and are greater for older people, people on low incomes and people with chronic illnesses.

Yet the current health budget debate continues to focus on raising these out of pocket costs, promoting the misperception that individuals, particularly older Australians and those with chronic and complex conditions, are largely responsible for the rising costs in the health system and must pay more.

This trend toward shifting health care costs from government to consumers through co-payments does not change the overall cost of health care. It can, instead, add more complexity and administrative burden. The sick will pay more, while the well will pay less. Any anticipated short term reduction in the demand for health care services will reduce access and as such increase health care costs over the longer-term.

The impact of co-payments

The evidence is clear - co-payments cause financial hardship and decrease access to health care for many people, but particularly so for older people. An ABS survey released in 2010[iii] revealed that some people delay or do not get some types of medical care due to cost. For example 1 in 16 people had delayed seeing or not seen a GP; around 1 in 11 people with a prescription had delayed getting or did not get their medication; and around 1 in 10 people referred to a medical specialist had delayed seeing or did not see the specialist.

More recent research and a survey commissioned by the Consumer Health Forum[iv], found that co-payments in health care:

- Impact more on older people, people on low incomes, and people with chronic illnesses.
- Result in people delaying treatments, leading to higher health costs overall.
- Increase the risk of compounding existing problems and further disadvantaging people.
- Result in decreased access to health care - the decrease in access being proportional to the size of the co-payment.
- Result in a decrease in both high and low value services (not just the so-called 'unnecessary' services).
- Do not generate overall cost savings for the health system.
- Result in increased downstream health care costs.

The current system can work well for those who have single or short-term health conditions. However, people with chronic, complex conditions that require a range of treatments and interventions are often faced with insurmountable financial and access issues. Associated pharmaceuticals, diagnostic tests and allied health treatments can all have unanticipated hefty gap fees, making people reluctant to follow through with the prescribed treatments. Previous increases to PBS co-payments resulted in a significant decrease in dispensing volumes for essential medicines such as anti-epileptic, anti-Parkinson's, asthma, insulin and osteoporosis medicines.

While the PBS and Medicare safety nets are designed to help with some of these costs, current policy means brand premiums (in PBS) and above scheduled fees (in Medicare) do not count in the annual threshold. In their current form these safety nets provide limited assistance, are administratively burdensome, and disproportionately advantage those living in wealthy electorates[v]. Of particular concern is the administrative requirement for the PBS safety net, where individuals or pharmacists must keep the record. More people could benefit from the PBS safety net if the eligible costs were automatically recorded, as is the case with Medicare.

Given the evidence of the negative impact of co-payments on consumers, nil bottom line cost savings for the health system, and the broader design and systemic issues with Medicare, COTA believes that the current inequitable system of co-payments must be examined as part of a comprehensive review of Medicare.

Implications for the ongoing sustainability of the health system

Access to affordable and quality health care is consistently identified as a priority issue for older Australians. This includes access to primary health care, hospital-based services, medications, information and activities that help people age well.

It is agreed that health costs are rising, with forecasts showing that health will rise from 9 per of GDP to 12 per cent in 20 years if the current policy settings are not changed. COTA does not support any increase in co-payments on the premise of addressing this so-called 'unsustainable' funding crisis. COTA is very concerned that an emotional reaction to this prediction, i.e. blaming older people and the disadvantaged, will see policy changes that will impact on the most vulnerable in our society. There needs to be a broader debate about community expectations and values in relation to how much of our GDP and tax revenues we think is reasonable to allocate to health care.

Older people clearly value Medicare and want to see the continuation of a universal health system that ensures equity of access to health care regardless of means. There is a growing perception that the universality of Medicare has been diluted and access to health services is becoming more dependent on income and geographic location.

There is growing acceptance that there need to be changes to the way healthcare is funded and delivered to ensure that the community is getting benefit from the increased spending and that the benefits are distributed appropriately.

We already know that the current fee for service model does not deliver good health outcomes for people with complex and chronic conditions, and we have advocated for the need to move to a more performance based funding arrangement that pays for health outcomes for consumers and improves the capacity of health professionals to take a restorative approach, and to work with their patients to manage their conditions.

COTA does not support the adoption of a suite of short to medium term measures as outlined in Recommendations 17 and 19 of the Commission of Audit Report, which relate to the terms of reference of this inquiry. We believe these recommendations significantly undermine the universal nature of our health system and move Australia towards a health system similar to the United States, which is more expensive and has greater health inequalities.

Introducing co-payments for GP visits, emergency departments and medicines will mean basic health care is compromised for many seniors, and this will be counterproductive to containing health care costs. We are already seeing 1 in 10 people putting off going to a GP because they cannot afford it. A new co-payment would increase that number and could lead to higher costs downstream as a result of people not seeking treatment early enough. It would also be counter to the findings of the Productivity Commission, which reported in 2013 that greater access to effective community interventions could avoid between 600,000 and 750,000 public hospital admissions.

COTA is very concerned about the introduction of a funding envelope for the PBS for what has been to date an open ended scheme, although with tight procedures for including new drugs. This will lead to restricting access to drugs, setting limits on individuals, and deferring the addition of new drugs to the schedule.

COTA does not believe a case has been made for increasing the co-payments and changes to the safety net arrangements. Both of these measures will increase the cost of medications. For people who are on multiple medications this would be quite a financial burden. We know many older people on low incomes already forego necessary medications because of the cost and this measure will exacerbate this problem.

There are more effective ways of managing health system expenditure without undermining the equity of access and further increasing the financial burden on those who can least afford it. COTA would strongly urge this committee to ask the government to carefully consider the probable negative impact of some of these recommendations and implement a proper review before making any decisions on them.

COTA joins others in the call for a system that places emphasis on the social determinants of health, such as employment, housing and transport; for preventative and restorative interventions that have been proven to reduce expensive hospital stays and improve quality of life. A comprehensive review of Medicare would facilitate discussion of how to achieve this.

COTA is also concerned that co-payments, set by governments, healthcare providers and others, are determined without any guidance from the community, and in the absence of any overarching policy framework or guiding principles. There must be broad community consultation and further research on the impact of co-payments, particularly those with chronic and complex conditions.

Access to good quality health services is a priority. We are calling for a systematic review of Medicare to ensure this is a reality and for no increase in out of pocket expenses for health. COTA strongly supports the development of a future health reform package as we think there are areas that need improving. COTA would welcome the opportunity to participate in the discussions of how we can make the health system work better for all Australians.

RECOMMENDATIONS

The Government commission a full independent review of Medicare to look at how it can be remodelled to improve access to good quality health care, with a view to moving to a more performance based funding arrangement that pays for health outcomes for consumers and improves the capacity of health professionals to take a restorative approach, and to work with their patient to manage their conditions. This would include:

- Broad community consultation to establish community expectations and values on how much of our GDP we think is reasonable to allocate to health care.
- Broad community consultation and further research on the impact of co-payments, particularly for those with chronic and complex conditions, with a view to developing an overarching policy framework and/or guiding principles for setting co-payments.
- Any future role, and impact of, private health insurance in covering out of pocket expenses for primary health care.
- Examination of how consumer directed and restorative models of care can be integrated into the overall health care system.
- Examination of how the out of pocket expenses for diagnostic testing and imaging can be more transparent and equitable.
- Examination of how the current complexities, inefficiencies and inequities in the current safety nets for both Medicare and PBS can be addressed.
- Examination of how changes to pharmaceutical prescribing methods, such as use of active ingredient, rather than brand name, could be implemented and thus reduce costs to the consumer and the health system.

This comment from one of our Election Panel members sums it up: "*we should have the best health system in the world and it should be available to all - not just the rich. The 'gap' payments are becoming untenable! - even if you have private insurance you find that the extra payments are huge!*"

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[i] Mend Medicare Report August 2013: Mend Medicare Coalition http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf

[ii] Empty Pockets: Why Co-payments are not the solution, Report by Jennifer Doggett, Consumers Health Forum of Australia March 2014 https://www.chf.org.au/pdfs/chf/Empty-Pockets_Why-copayments-are-not-the-solution_Final-OOP-report.pdf

[iii] ABS, (2010) Health Services: Patient experiences in Australia 2009

[iv] Empty Pockets: op cit; Consumers Health Forum results to date on-line survey of health consumers https://www.chf.org.au/pdfs/med/MED-20140303--Copayments_Empty-Pockets.pdf

[v] Department of Health and Ageing 2012 "Facts and Figures: Electorate Reports on Health Data", cited in Mend Medicare Report op cit