



OUT OF POCKET

Rethinking health copayments

Jennifer Doggett

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KEY POINTS

Consumer co-payments are the “out of pocket” payments that consumers make directly for health and medical care which are not rebated by Medicare, private health insurance or other sources.

Co-payments comprise the third largest source of health funding in Australia, after Federal and State/Territory Governments. They contribute over \$15 billion a year to the health system, which is more than double the \$6.3 billion paid via private health insurance (2005-06 figures). Co-payments comprise 17% of health spending in Australia, a higher proportion than in 13 out of 20 OECD countries, including the USA.

Although consumer co-payments influence both how consumers access health care and which goods and services they access, they receive little political or policy attention.

The result of this policy neglect is a ‘system’ of co-payments which:

- » is inequitable, discriminating against consumers with certain types of health care needs or who live in particular geographic areas;
- » is complex, expensive to administer and confusing to both consumers and providers;
- » creates barriers to accessing cost-effective health care, typically imposing the highest costs on consumers when they have the least ability to pay; and
- » results in perverse incentives in the use of health care.

Studies have found that over a third (36%) of Australians with chronic conditions reported problems with accessing health care due to cost; 17% of Australians had “skipped a medical treatment, test or follow-up recommended by a doctor, because of cost”; and 35% of Australians reported not accessing dental treatment due to its cost. When people are not able to access appropriate care, their condition can become more serious which results in increased expenses both to them and to the community as a whole.

Private health insurance does not provide an adequate solution to these problems. Fixed rebates combined with open ended co-payments do not provide consumers with ‘insurance’ in the sense of capping their risk. Rather they act as an expensive and inefficient budgeting measure to assist consumers with managing health care expenses.

The starting point for addressing the significant equity and efficiency issues associated with our current system is to develop a national approach to co-payments for health care. Innovative policy solutions should be considered, such as the following:

1. Giving all consumers a ‘Health Credit Card’ to pay for health care without upfront payments. The Federal Government would then assume responsibility for paying health care providers directly and bill consumers for the out-of-pocket costs.

2. Creating a single comprehensive safety-net for all health-related goods and services (incorporating the existing Medicare and PBS safety-nets) to target consumers who have difficulty affording health care.
3. Providing greater choice for consumers in public health care, through allowing them to trade public hospital benefits for higher primary care subsidies and/or pay additional fees for non-medical services.

The above strategies would significantly improve both the equity and efficiency of our health system. Governments and policy makers cannot continue to ignore this important component of health funding without seriously compromising the future of public health care in Australia.

Introduction

Direct consumer payments for health care play an important but often overlooked role in our health system. Currently more than one in six dollars spent on health care in Australia comes directly out of consumers' pockets. Co-payments comprise the third largest source of health funding in Australia (after Federal and State/Territory Governments). They contribute over \$15 billion a year to the health system, which is more than double the \$6.3 billion paid via private health insurance (2005-06 figures)¹. Co-payments comprise 17% of health spending in Australia, a higher proportion than in 13 out of 20 OECD countries. This includes the USA where consumers contribute only 13% of total health care costs in direct payments².

Although consumer co-payments influence both how consumers access health care and which goods and services they access, they receive little political or policy attention. There has been no attempt to develop a national policy on co-payments within the health system and no coordinated approach between governments and health providers to assess the impact of co-payments on consumers. Current health care reform proposals³ are mainly directed towards changing responsibilities for funding and service delivery between levels of government, or shifting them to new organisations (for example 'regional health authorities') and largely ignore the issue of direct consumer payments.

Reports in the media on health funding issues consistently focus on disputes between different levels of government, ignoring the fact that over the last decade the proportion of health funding contributed by the Commonwealth and State/Territory governments has remained fairly static. In fact, in the ten years between 1995-96 and 2005-06, the Federal Government's contribution of total health funding has dropped only slightly from 43.1% to 42.9%, while the States/Territories share rose from 23.1% to 24.9%⁴. The focus on jurisdictional disputes over health funding also ignores the fact that it makes little difference to consumers whether public funding for health care is channelled through federal or state governments.

What are consumer co-payments?

Consumer co-payments are the payments that consumers make directly for health and medical care which are not rebated by Medicare, private health insurance or other sources. They are also called "gap" payments or "out of pocket" costs. A co-payment can be a small proportion of the overall cost of a good or service or it can make up the total cost. Examples of consumer co-payments within the health system are:

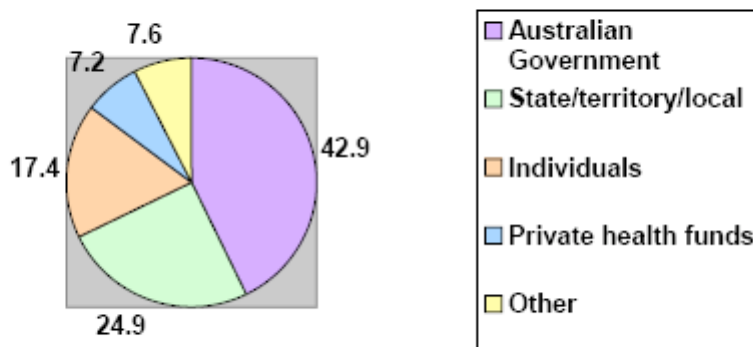
- the "gap" between the fee for a doctor's consultation and the amount rebated by Medicare;
- the "gap" between the fee for a dental or allied health consultation and the amount rebated by a private health insurance fund (for someone with private health insurance);
- the total cost of a dental or allied health consultation (for someone without private health insurance);
- the cost of prescription medicines to the consumer (after the subsidy for PBS-listed medicines has been applied)
- the total cost of "over the counter" medicines, such as aspirin and cough syrup
- the total cost of natural and complementary medicines, such as vitamins and nutritional supplements
- the net cost of medical devices (after any subsidies and rebates are applied), such as prostheses, dental devices and syringes.

While this paper focuses on monetary payments, it should be recognised that there are a range of non-monetary forms of co-payment, such as waiting times for treatment, which also have broader resource implications.

Compared with the scrutiny received by changes in government funding for health care, increases in consumer co-payments occur with little oversight by policy makers, consumers or the media. The result of this policy neglect is a 'system' of co-payments which:

- » is inequitable, discriminating against consumers with certain types of health care needs or who live in particular geographic areas;
- » creates barriers to accessing cost-effective health care;
- » is confusing to both consumers and providers;
- » results in perverse incentives in the use of health care;
- » is complex and expensive to administer;
- » typically imposes the highest costs on consumers when they have the least ability to pay; and
- » does not support the diversity of consumer health care needs or promote consumer choice.

Percentage of total health funding by source 2005-06



Source: AIHW Australia's Health 2008

NB 'Other' includes non-government sources such as compulsory third-party motor vehicle and workers compensation insurers

Over the past decade, there has been a trend towards increasing co-payments for health services. Given that health and medical costs are rising (due to factors such as the introduction of expensive new technologies and treatments), the burden of health care costs on individuals is likely to continue to increase. Unless a more effective system of co-payments for health care is developed, this trend will threaten the overall equity and efficiency of our health system and undermine the effectiveness of other health system reform proposals.

Consumer co-payments in the Australian health system

Most forms of health care in Australia involve some form of direct consumer payment but these vary 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.

The following table demonstrates the levels of direct consumer contributions for different types of health care (2005/06 figures).

This means that consumers contribute an average of 97 cents in direct payments for every dollar spent on non-prescription medications but only 11 cents in every dollar spent on medical services.

Limited and open-ended co-payments: an important distinction

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.

Area of expenditure	Individual payments \$m	Total Payments \$m	Individual payments as a % of total
Non-PBS/RPBS medications ⁵	4 036	4 216	97%
Aids and appliances	2 072	2 787	74.3%
Dental	3 573	5 337	66.9%
Other health practitioners ⁶	1 653	3 035	54.5%
PBS /RPBS medications	1 240	7 286	17%
Medical services ⁷	1 745	15 499	11.3%

SOURCE: AIHW AUSTRALIA'S HEALTH 2008

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. For some forms of care the total fee is set by private providers and in others it is determined by government policy. The variation in the way co-payments are imposed within the health system is illustrated by the following case study⁸.

Case study 1

Liz injures her knee playing netball. After visiting the GP she is referred to a specialist and requires an

MRI scan. The specialist recommends surgery, which takes place in a private hospital, followed by some physiotherapy. The following table outlines the health care Liz requires for this injury, together with the sources of funding and proportion of each good/service which is subsidised by either public or private insurance.

Service/goods	Payment mechanism	Sources of funding	% cost of service subsidised*
GP visit	No out-of-pocket cost to consumer (bulkbilled)	Medicare	100%
OTC painkillers	Consumer pays total cost upfront	Direct consumer payment	0%
Specialist consultation – in rooms	Consumer pays total cost upfront and receives rebate at a later date	Medicare + co-payment	50%
MRI	Consumer pays total cost upfront and receives a rebate at a later date	Medicare + co-payment	40%
Physiotherapy	Consumer pays total cost upfront and receives a rebate at a later date	Private health insurance + co-payment	60%
Hospital procedure – medical (surgeon and anaesthetist)	Consumer pays the ‘gap’ amount (cost of procedure minus rebate)	Medicare + co-payment	45%
Hospital procedure – hospital charges	Consumer pays total cost after the procedure and receives a rebate at a later date	Private health insurance + co-payment	85%
Hire of crutches	Consumer pays total cost upfront and receives a rebate at a later date	Private health insurance	100%
Hire of exercise equipment	Consumer pays total cost upfront	Direct consumer payment	0%
Prescription painkillers	Consumer pays ‘gap’ amount (cost minus subsidy) upfront	PBS + co-payment	90%
Dressings	Consumer pays total cost upfront	Direct consumer payment	0%

* BY EITHER PUBLIC OR PRIVATE INSURANCE, NOT INCLUDING ANY RELEVANT SAFETY-NETS

For a treatment program for a single injury, Liz is required to use six different payment mechanisms, make multiple transactions with providers and receive health goods/services with eight different levels of subsidy, ranging from 0% to 100% of the total cost.

SAFETY-NETS

Currently there are three main safety-nets in place within the Australian health system which aim to provide additional subsidies for high-level users of health and medical care. They operate as follows.

Medicare Safety Net

The Medicare safety-net⁹ 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. The first level meets the cost of the 'gap' (i.e. it rebates 100% of the schedule fee) for out-of-hospital services, once a threshold is reached. The next two levels pay for 80% of all out-of-pocket costs for out-of-hospital services, with two different thresholds depending on consumers' income level and responsibility for dependents. These are summarised below.

Level	Threshold	Who is it for?	How is it calculated?	Benefit to customers
Gap	\$383.90	All Medicare card holders	Based on gap between the Medicare benefit and the schedule fee.	Medicare benefit increases to 100% of schedule fee for out-of-hospital services
Concession and FTB(A)	\$555.70	Concession card holders. Families eligible for Family Tax Benefit A	Out of pocket costs	Government pays 80% of out-of-pocket costs for out-of-hospital services
General	\$1111.60	All Medicare card holders	Out of pocket costs	Government pays 80% of out-of-pocket costs for out-of-hospital services*

* AS ANNOUNCED IN THE FEDERAL BUDGET 2009-10, FROM 1 JANUARY 2010 THERE WILL BE UPPER LIMITS PLACED ON THE BENEFITS THAT CAN BE PAID FOR SOME SERVICES

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 70% or 80% of the Schedule Fee depending on whether the service is delivered in a hospital or in a community setting. 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 parts of the Medicare Safety Net.

Pharmaceutical Benefits Scheme Safety Net

The PBS safety-net¹⁰ 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.

	PBS Safety Net threshold	PBS contribution once threshold reached
General patients	\$1264.90	\$5.30
Concession card holders	\$318.00	FREE

Medical Expenses Tax Offset

The net medical expenses tax offset¹¹ 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, and nurses
- » to both public and private hospitals
- » to dentists, orthodontists or registered dental mechanics
- » to opticians or optometrists, including for the cost of prescription spectacles or contact lenses
- » to a carer who looks after a person who is blind or permanently confined to a bed or wheelchair
- » for therapeutic treatment under the direction of a doctor
- » for medical aids prescribed by a doctor
- » for artificial limbs or eyes and hearing aids
- » for maintaining a properly trained dog for guiding or assisting people with a disability (but not for social therapy)
- » for laser eye surgery, and
- » for treatment under an in-vitro fertilisation program

Some services (such as cosmetic surgery) are excluded from the tax offset.

Health Care Cards

Health Care Cards (HCCs)¹² 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.

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 concessionally bill) pensioners and/or children and local councils who provide discounts on home help services for pensioners.

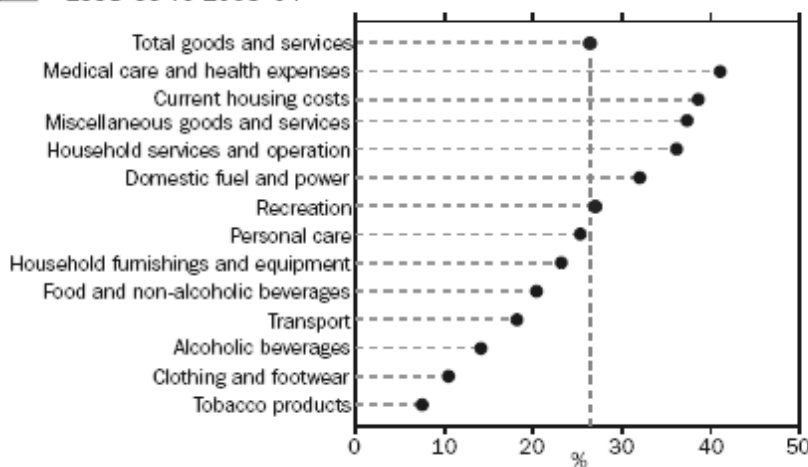
There are also some individual targeted schemes for people who use specific forms of health and medical care, such as the Continence Aids Assistance Scheme, which provides subsidies for people requiring the long-term use of continence products.

TRENDS IN CO-PAYMENTS

Over the past decade, Australians have been paying more for healthcare overall and a higher percentage of health funding is coming from co-payments. Between 1995-96 and 2005-06 direct consumer contribution for health services increased by 11.5%, from 15.6% to 17.4% of total health funding or just over \$15 billion a year¹³.

Australian Bureau of Statistics data shows that medical and health expenses are the fastest growing area of household expenditure, increasing by over 40% between 1998/99 and 2003/04.

4 INCREASE IN AVERAGE WEEKLY EXPENDITURE ON GOODS AND SERVICES, 1998-99 TO 2003-04



SOURCE: HOUSEHOLD EXPENDITURE SURVEY 2003-04 AUSTRALIAN BUREAU OF STATISTICS 2007

The National Centre for Social and Economic Modelling (NATSEM) supports 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.”¹⁴

CO-PAYMENTS AND PRIVATE HEALTH INSURANCE

Co-payments associated with health goods and services covered by private health insurance play an important role in influencing consumers' access to private health care. Private health insurance within the Australian health system provides consumers with two distinct services. It reduces the risk to each health fund member of incurring high health care expenses by capping the amount members have to pay (the excess) in the event of some high-cost forms of treatment (e.g. private hospital care). Overall, this has the effect of transferring health care costs from lower level users to higher level users. It also assists health fund members to spread the cost of their health care over time, through paying fixed rebates for other lower cost forms of health care (e.g. ancillary services).

It is important to note that fixed rebates combined with open ended co-payments, such as those required for ancillary services by most forms of private health insurance, do not really provide consumers with 'insurance' in the sense of capping their risk. Rather they act as a budgeting measure to assist consumers with managing health care expenses.

While some people may find this helpful, it does not meet the needs of many health care consumers. For example, 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 treatment¹⁵. Another disadvantage of private health insurance is that rebates can suppress price signals, as the consumer pays only the 'gap' amount and in some cases of 'gap insurance' pays nothing at the point of service. This occurs also with other forms of health care subsidy, such as Medicare. However, as private health insurance funds do not have the same capacity as large government programs to contain costs, the suppression of price signals by private health insurance is much more likely to lead to fee inflation (since providers can raise their fees knowing that consumers will not have to directly bear the increased cost). This results in much higher overall health care costs to the community¹⁶.

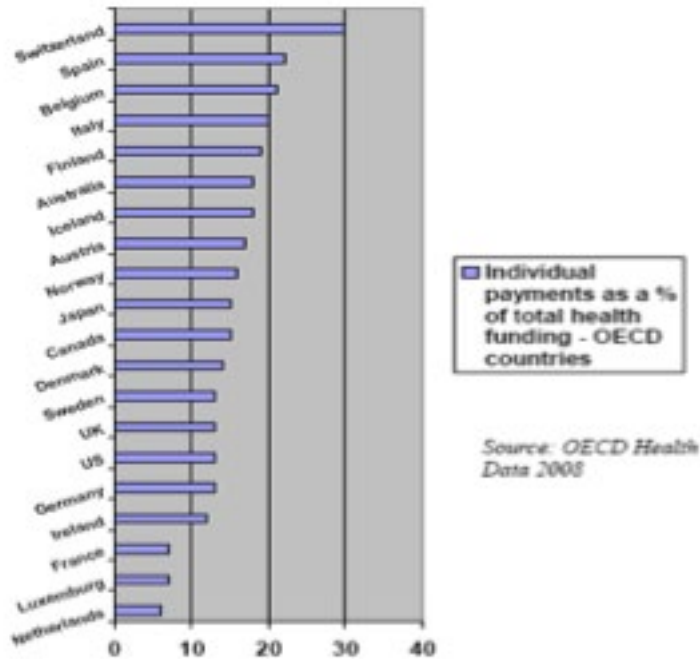
While an insurance model may be appropriate to meet the first function of private health insurance – that is to share the risk of unusually high health care expenses among members¹⁷ – it is an overly complex, expensive and often ineffective approach to helping consumers with average or low health care needs budget for their health care costs. Given that (by definition) the majority of health consumers are not high level users of health care, private health insurance should not be supported or subsidised by government as a mechanism for funding health services. A better solution to assist consumers to budget for health care expenses is outlined below.

INTERNATIONAL COMPARISONS

Australia's health system is often presented as being more egalitarian than that of many other countries¹⁸. It may come as a surprise therefore to learn that Australians pay for a higher proportion of their health care directly out of their own pockets (as opposed to via public or private insurance) than citizens from 13 of 20 other OECD countries¹⁹, including the UK, Japan, Germany, France and the Netherlands²⁰. Out of these countries, only Switzerland, Spain, Belgium, Italy and Finland have higher rates of co-payments than Australia. Even Americans, though they pay more overall than Australians for their health

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care, contribute only 13% of their total health funding through direct payments (compared with over 17% for Australians). While the US health system clearly has other equity problems (for example the high number of uninsured people), Americans with health insurance share their health care costs more equitably with each other than do Australians²¹.



Consumer co-payments: the main issues

Consumer co-payments are a widely used form of health care funding in almost all health systems around the world. Like any form of payment for health care, co-payments have advantages and disadvantages and their impact varies significantly depending on the way in which they are implemented.

Many of the problems associated with co-payments in Australia are due to the fact that our current system of co-payments has developed in an ad hoc manner without an overall policy context or a coordinated approach between the providers and funders of health care. Government programs involving co-payments have been treated in isolation from each other and different arrangements for co-payments have been introduced without consideration of their overall impact on consumers. In some cases the introduction of (or increase in) co-payments is the result of a deliberate policy decision (for example increases in PBS co-payments) and in others it occurs without any government policy oversight (for example, when a GP decides to stop bulkbilling). Despite the fact that co-payments can have a significant influence over consumers' capacity to access health care, there is no government agency, departmental area or joint Commonwealth-State body responsible for monitoring and assessing the overall impact of co-payments in health care on consumers.

This lack of an overall policy framework has made it difficult to develop a rational, fair and integrated approach to co-payments which supports the efficient use of health care resources. The result of this is a reduction in both the equity and efficiency of our health system, as discussed in more detail below.

EQUITY ISSUES

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 our health system.

This is because, 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 means that the sick pay more than the healthy and the poor pay more – as a share of their income – than the well-off, for the health care they require.

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.

This inequity is compounded in the case of health services that require up-front payments, which can present particular access issues for people with 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).

Case study 2

Michelle and Petra have the same level of income and the same capacity to pay for their health and medical care. Both women have used health and medical services over the past three years that have a value of \$20 000. However, of the \$20 000 of health care used by each woman, Michelle has contributed \$8 000 in co-payments and Petra has contributed only \$200. This is because Michelle has rheumatoid arthritis and requires regular treatment from a physiotherapist and uses high levels of non-prescription pharmaceuticals (along with GP and specialist care). Petra's health care needs however have primarily centred on public hospital care for the birth of her two babies, one of which required an operation shortly after birth and an extended hospital stay.

The current system of co-payments impacts unfairly on different consumers, depending on their health care needs. 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.

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 services²². 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 shortages²³. 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. 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.

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, will 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 costs²⁴. This results in an inequitable allocation of health care resources and has a particularly negative impact on people with chronic conditions.

Research conducted by NATSEM for the NHHRC²⁵ found that while the relationship between income level and health care costs is complex, for families that incur health costs, those in the lowest income quintile spend a greater proportion of their total household expenditure on health items than those in the upper quintiles. For example, dental costs made up 8.18% of the total weekly household expenditure for bottom income quintile families who incurred dental expenses. For families in the top quintile

who paid for dental care, these costs made up only 1.72% of their total expenditure. On the basis of its extensive modeling, NATSEM concluded that these inequalities in expenditure patterns by household income are further exaggerated when wealth is considered.

Because there is no coordinated approach to this issue, the inequity in the impact of co-payments on consumers is often not obvious to governments, policy makers and service providers when considering individual health programs. A small increase in PBS co-payments by the Federal Government may not impose undue hardship on consumers in isolation. However, 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, the compounding effect of these increases can place a significant burden on individuals and families, depending on their health care needs.

ACCESS ISSUES

One of the problems in developing a comprehensive policy on co-payments is the lack of comprehensive data on the impact of co-payments on consumers. However, there is evidence that the current system of co-payments is creating barriers to access among some groups of consumers, in particular those with chronic conditions.

For example, a survey of 325 clients conducted by the Bobby Goldsmith Foundation²⁶ found that many had experienced problems managing their health-related expenses. Specifically, around 46% responded that they experienced difficulty with purchasing HIV medications, 60% with purchasing other prescribed medication, 44% experienced difficulty with costs relating to medical or dental fees and 41% with the costs related to alternative and complementary therapies.

A study undertaken by the Chronic Illness Alliance²⁷ found that the costs of both medication and associated needs are a major contributor to hardship for all people with chronic illness, regardless of income. This study found some people with chronic illness spend major proportions of their incomes on medication in order to remain independent.

Another research project conducted by Dr Christine Walker from the Chronic Illness Alliance²⁸ 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.

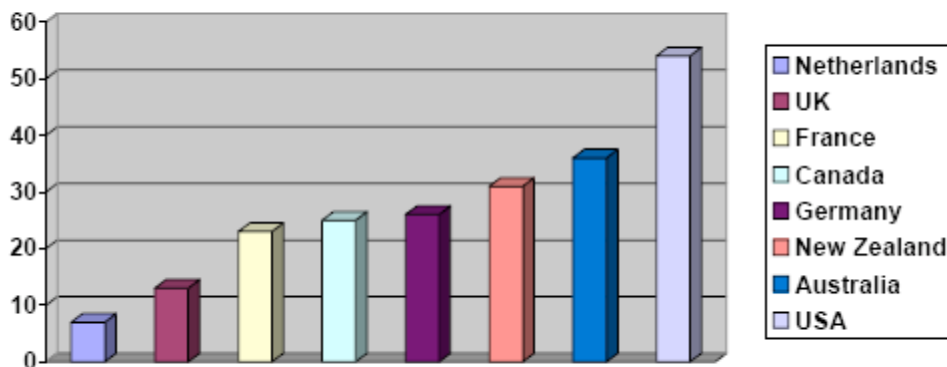
Larger-scale surveys support the finding of these studies that health care costs are restricting access to health care for some consumers. For example, the Commonwealth Fund's 2007 survey²⁹, conducted in seven OECD countries, found that a significant proportion of Australians report missing out on health care due to cost issues.

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For example, 17% of Australians surveyed reported that they had “skipped a medical treatment, test or follow-up recommended by a doctor, because of cost” (more than citizens of any other country apart from the USA). And 35% of Australians reported not accessing dental treatment due to its cost (more than people in all other countries, apart from New Zealand). Currently, there are an estimated 485,000 people on waiting lists for public dental services. Many of these people start out on waiting lists needing preventive or restorative treatment but end up losing their teeth because of delays in receiving care.

A similar 2008 survey³⁰ by the Commonwealth Fund of chronically ill adults in Australia, Canada, France, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States found that over a third (36%) of Australians with chronic conditions surveyed reported problems with accessing health care due to cost. This was higher than participants from any other country, apart from the US.

Percentage of people with chronic conditions who experienced access problems due to cost over the past two years



Source: Commonwealth Fund 2008

The high number of preventable hospital admissions (estimated by the Australian Institute of Health and Welfare to be over 675 000 or 9.3% of all admissions in 2005/06) also suggests that many people are not accessing preventive care in the community, due to the cost of the care or other access issues. Creating barriers to accessing appropriate health care can impose additional costs on the community, including the cost of treating more serious and longer-term health problems and the associated loss of productivity.

The fact that Australia spends about the average of all OECD countries on health and has a high level of government involvement in health care means that we have both the resources and the capacity to ensure that all Australians can access preventive health care. Problems associated with co-payments are a major reason why many consumers do not access the care they require to maximise their health and to prevent the development of more serious illnesses and disabilities. This is a failure of policy and of political leadership, not the result of an overall lack of funding for health care.

Case study 3

Joe is a low income earner who cannot afford the up-front cost of private dental services. He develops dental problems and is put on a public dental services waiting list. While still waiting for treatment his problems become acute and require treatment at a public hospital. As a result of this treatment he loses several teeth, which will affect his future opportunities for employment as well as his quality of life. The overall cost to the community of his public hospital treatment and ongoing dental problems is far higher than the cost of private preventive dental care.

Our current system of co-payments can deter people from seeking early and preventive care, resulting in higher health care costs over the longer term.

EFFICIENCY ISSUES

One of the potential advantages of consumer co-payments is that they can help send price signals to consumers and so discourage the excessive use of health services. This is one reason often given by governments for introducing co-payments, although in reality co-payments in the health system often result in a decrease in both excessive and appropriate uses of health care³¹.

However, for this advantage to be realised there needs to be a connection between co-payments and the value of health goods and services. This would improve both allocative efficiency (allocating resources where they will achieve the greatest benefit) and technical efficiency (ensuring resources are used to deliver maximum output). One of the major problems with the role of co-payments within our health system is that 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 to the value of that service or good to individuals or to the community as a whole. This means that co-payments do not send effective signals to consumers about their best choice between alternative health care options and do not support either allocative or technical efficiency. Low-cost preventive health services (such as basic dental care) are often subsidised at a lower rate than higher cost acute care services (such as public hospital treatment). This creates an incentive for consumers to choose more expensive forms of health care, even if they are less effective, thus increasing the overall cost of health care to the community as well as reducing individual health and well-being³².

Furthermore, the introduction or raising of co-payments at the program or service level does not support the overall goal of maximising health care resources. For example, governments may increase co-payments for a health service where the cost of the program is growing rapidly, regardless of whether or not the service is delivering value for money. This reflects the general lack of a system-wide approach to health policy by governments and a focus on the short-term fiscal costs of individual programs, rather than long-term economic costs associated with health care³³. Co-payments often simply act to shift the cost of health care from governments to consumers, which may benefit governments concerned about reducing program budgets but can often result in higher longer term health care costs to the community.

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Linking co-payments directly with the value of the associated health good or service 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.

It is also important to look at the actual impact of co-payments on utilisation, as 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 spending³⁴.

There is also evidence that co-payments may act as a particularly effective deterrent in areas of health care that are already under-utilised, such as mental health services³⁵.

In addition, the impact of any likely reduction in demand on the fees set by health care providers also needs to be considered, as if prices increase, this could undermine the potential gains provided by demand reduction. Providers have a significant influence over the cost of health care in Australia's large private health sector and their response to any changes in co-payment policies will affect their overall impact. As the data currently available on how providers respond to changes in payment practices is not comprehensive this may require additional research and modelling.

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 only work for some people, some of the time. Overall they do not address the broad range of issues resulting from our current system of co-payments and do not provide adequate assistance to many health care consumers in accessing the care they require. 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.

Specific problems with the current system of safety-nets are as follows:

- » they are difficult to understand and often require consumers to keep records of their expenses

and apply for benefits³⁶. 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). This makes 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 often advantage people on higher incomes, as they typically use more expensive forms of health care, such as private medical care, compared with those on lower incomes. The Medicare safety-net has been shown to provide significantly higher benefits to people in the most affluent electorates compared to the least affluent³⁷;

» some health providers are able to change their behaviour, such as raising their fees or shifting the site of their care to take advantage of safety-nets. This results in higher health costs to the community without corresponding benefits to consumers³⁸. It can also create a perverse incentive to provide care in a setting which may not be the most appropriate for consumers, in terms of quality, safety or convenience;

» 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 (see case study below);

» 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;

» 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 does not support the most efficient use of health care resources and creates inequities in access among consumers; and

» they primarily focus on medical treatment and prescription pharmaceuticals and do not cover many other forms of health care. This disadvantages consumers who require other health goods and services (such as allied health care, over-the-counter pharmaceuticals and medical devices) for their conditions.

Case study 4

David and Antonio are both teachers in their 20s earning \$65k per annum. David 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. Antonio has Hepatitis C and requires regular health care, including frequent GP and specialist consultations, prescription medication, over-the-counter supplements and Chinese medicine. He also sees a psychologist for depression 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, David receives a \$2100 rebate via the Medicare safety-net. However, Antonio receives only \$80.

Over a five year period, David's health care expenses total \$3500 and Antonio's are \$5000. However, David receives a total of \$2100 in Medicare safety-net rebates and Antonio receives only \$400.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total costs	Total rebate	Net costs
David	\$3500	0	0	0	0	\$3500	\$2100	\$1400
Antonio	\$1000	\$1000	\$1000	\$1000	\$1000	\$5000	\$400	\$4600

Although Antonio's illness is more serious and more expensive than David's, he receives significantly less in government subsidies for his care under the current safety-net system. This is because safety-nets are based on 12 month rather than ongoing expenditure.

While minor reforms to the safety-net system, such as those undertaken in the 2009/10 Federal Budget, can address some of the above issues, piecemeal changes will only have a limited effect. A major restructure of all current safety-nets is required in order to address the problems outlined above. This is discussed in more detail below.

A new policy framework

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.

Fundamental questions which need to be asked as part of developing a policy on co-payments for health services include addressing whether co-payments 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? Which groups in the community will reduce their consumption?)
- » 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?)

Answering these questions will go a long way towards clarifying the role of co-payments within our health system and in reaching agreement between governments, health care providers, health service managers and consumers on their aims and objectives.

This can only occur in the context of a community debate on the fundamental principles underlying our health system. Rather than focus on health financing issues such as the division of funding responsibility between the Commonwealth and the States/Territories or between public or private insurance, discussions on health resource allocation should acknowledge 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) and instead address how it can best be allocated to deliver maximum benefits to consumers in a way that reflects community priorities and values.

Fundamental to this process is determining what proportion of health costs consumers want to share with others (for example via Medicare or private health insurance) and what proportion should be funded directly by individuals (for example through direct payments)³⁹. This distinction is far more important than debating which level of government or organisation administers the funding. Sharing health care costs with the community (such as in government programs like Medicare and the PBS) or with a smaller population group (such as in private health insurance where costs are shared with other members of a

health fund and via reinsurance processes with all insured people) is fundamentally different from other mechanisms of funding health care, for example via co-payments or health savings accounts, where individuals are responsible for meeting their own health care costs.

Finding the appropriate balance between pooled and individual funding for health care is an issue which will significantly influence the future of our health system. However, the extent to which we share the burden of our health costs with others is usually ignored in the debate over health funding. For example, the interim report from the National Health and Hospitals Reform Commission states that the balance between private and public funding has public approval and should remain⁴⁰. Given that there has never been a broad community consultation on this issue, the Commission's conclusion is questionable, particularly given the increasing preference for public spending on health and education over tax cuts expressed through opinion polls⁴¹. In cases in which informed consumer debate on health resources use takes place, for example, in the context of a citizens jury, the results suggest that community priorities for funding differ markedly from those reflected by our current health system⁴².

In the absence of a community debate on this issue, decisions about health funding are made by politicians, bureaucrats and health services managers rather than consumers. This can result in the balance between individual and pooled funding shifting significantly over time, without being guided by community preferences. Since the last major reform of health funding in Australia – the introduction of Medicare in 1983 – there have been major changes, both in the nature of health care needs of the community and in the ability of people to pay for health services. We are a wealthier, healthier, longer-living and more diverse community than we were in the 1980s. We arguably have a greater capacity to fund our own health care than we did a generation ago. 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. Therefore, it is not unreasonable that the contribution made by individuals to the cost of their care should have increased over this time and that we may need to change the way in which we pay for health care to reflect changing community values and priorities. However, these changes should be transparent and occur in the context of a community debate, rather than through piecemeal and ad hoc increases in co-payments without consideration of their overall impact on consumers, particularly those in vulnerable groups. In particular, any changes to the way in which we pay for health care should be guided by community values and support the efficient use of health resources.

THE POLICY CHALLENGE

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:

- » health care costs vary widely across the population. Some people require much more health care (or much more expensive forms of care) than others⁴³. If we care about equity within our health system we need a system of co-payments that treats people who incur the same level of health care

expenses and who have the same capacity to pay in the same way.

» health care needs are unpredictable. People usually don't plan to get sick or have an accident. This makes it difficult to budget for possible health care expenses. An efficient co-payment system needs to accommodate the unpredictability of health care needs.

» 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.

» 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.

SUGGESTED PRINCIPLES TO UNDERPIN A NEW APPROACH TO CO-PAYMENTS

The starting point for the development of a new approach to co-payments across the health system should be the development of a set of underlying principles. In the absence of a broad community consultation on this issue, the following principles are proposed as a starting point for debate:

Co-payments for health services should:

Reflect community values

Our health system is an important part of our society and should reflect the values and aspirations of our community. For example, if we value fairness and respect for diversity, our health funding system should attempt to maximise both equity and consumer choice in the allocation of health funding.

Create no up-front cost barriers to obtaining care

No-one should be denied access to the most cost-effective health care option for their condition because of an inability to meet required up-front payments. In particular, co-payments should never prevent consumers from accessing preventive care or seeking assistance to manage a chronic condition more effectively.

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, high up-front cost barriers for the most effective treatment options should be avoided, in particular where minimal or no costs are imposed for less cost-effective options.

Be fair in their application to different consumer groups

All consumers with the same capacity to pay should have access to the same level of subsidies for health care. Co-payments should not impact differently on people due to factors such as the timing of their illness or their geographic location. The varying ability of consumers to afford co-payments should be taken into account when developing the system.

Apply across the spectrum of the health system

Co-payments and safety-nets for health goods and services should be consistently applied across the health system. This includes both the public and private sectors, as well as Federal and State/Territory funded services and encompasses all forms of health and medical care, including dental services. Artificial barriers between different sectors of the health system create administrative inefficiencies and perverse incentives for consumers to access less effective forms of health care.

Have a clearly articulated purpose

It is important that the aims of co-payments are clear to consumers, governments and health care providers. As well as reflecting the community's values, the effectiveness of co-payments, including their level and the manner in which they are applied, should be evaluated against their objectives on a regular basis with particular consideration given to the impact of co-payments on disadvantaged and vulnerable groups. The results of these evaluations should be made available to health providers and the general community.

Be the best option to achieve this stated purpose

The use of co-payments to achieve the stated purpose should have a sound evidence base to demonstrate that they are the best option for this purpose. They should not be introduced without alternative options being considered.

Have a transparent and efficient system of administration

Consumers should be able to understand how the system of co-payments is administered and what their entitlements are in relation to accessing health care. The administration of co-payments should not be overly bureaucratic or complex.

Respect consumer choice and diversity

In their approach to health care, as in other areas of life, consumer needs and preferences differ. For example, there is wide variety in consumers' tolerance of risk and their willingness to pay for more choices or the security of capped expenses. A system of co-payments should support the diversity of consumer views on health care and provide as much flexibility as possible for consumers, while maintaining a strong focus on equity and social solidarity.

POLICY PROPOSALS

The following section outlines three strategies to develop a new system of co-payments for the Australian health system which reflect the principles outlined above. Together they would create a much more efficient and equitable system of health care payments, which could be adapted to reflect community values and consumer preferences.

PROPOSAL 1: HEALTH CREDIT CARD

The first step towards an integrated and comprehensive system of co-payments is to change the way we pay for health goods and services. The current system, in which individuals pay service providers directly and then seek rebates from one or more sources, wastes considerable time and resources of both consumers and providers. It also imposes irregular and often unpredictable payments on consumers which are administratively complex and can create budgeting difficulties. A better approach would be to centralise the payment mechanism for health goods and services to streamline the payments process and assist consumers in meeting irregular and unpredictable health care expenses. This would work as follows:

- » the Federal Government issues all consumers with a 'health credit card'⁴⁴ to be used to pay for all approved health goods and services (both private and public) with no cash upfront;
- » the Government (via Medicare Australia or a separate agency established for this purpose) assumes responsibility for paying providers the full amount of their fees for all health goods and services paid for by the health credit card;
- » the government agency deducts any subsidies and rebates, such as those covered by Medicare/PBS and (if applicable) private health insurance, and sends the consumer the bill for the outstanding gap amounts. Consumers receive consolidated bills at regular intervals, for example, monthly or quarterly, rather than separate bills for each service (similar to credit card statements with all individual services and costs itemised);
- » consumers have the option of making one payment for the total amount of all consolidated out-of-pocket costs for the given period or paying in instalments (similar to credit card payments) with minimal or no interest;
- » consumers are required to make a minimum payment but (unlike in the case of conventional credit cards⁴⁵) this would be indexed to consumers' ability to pay (based on income and assets) rather than the amount of the debt (similar to the Higher Education Contribution Scheme – HECS – for tertiary education). Minimum payments would be capped at a pre-determined level (for example 10% of after-tax income per annum), so that no consumers faced financial hardship due to their health and medical bills.

OUT OF POCKET: A NEW WAY TO PAY FOR HEALTH CARE

This major change in the way in which we pay for health services would have a number of advantages, including the following:

- » it meets both the needs of providers to receive prompt payment for goods and services and those of consumers to be able to pay for their health care over time, depending on their resources;
- » there would be no up-front cost barrier to consumers accessing services;
- » people could spread payments over a period of time, thus reducing problems arising from unexpected health care expenses;
- » it would help people to manage the costs of health care while maintaining price signals (as people would still have to pay for health services) and therefore support the efficient use of health resources;
- » it would be administratively simpler for consumers as they could receive and pay for all their health care costs through the one mechanism. This would result in considerable savings in time and resources compared with the current system;
- » it separates the provision of health care from the 'social security' function of subsidising care for those unable to meet their own costs. This means that providers do not need to know which consumers are receiving additional government subsidies, thus preserving the privacy of consumers and reducing the capacity for fee inflation;
- » it could be used as a vehicle for providing 'negative payments' to specific groups of consumers, where these have been shown to be effective⁴⁶;
- » it could be used to provide additional subsidies to groups of consumers who face higher than average costs to access health services, for example, to subsidise travel costs for consumers in rural and remote areas who are required to travel long distances to receive care;
- » it would reduce administration and paperwork for providers who would not need to process individual payments. It would also give them increased security as they could be confident that their fees would be paid and reduce the pressure on providers to identify and assist people who have trouble affording health care, and
- » it would reduce stress and uncertainty about medical costs as people would know that they never have to pay more than they could afford for medical and health expenses.

Case study 5

Josh has a cycling accident and injures his back. In the first month after his accident he requires treatment from a number of health care providers, including a GP, specialist physician, exercise physiologist and osteopath. In addition to this, he requires prescription pain relief medication and undergoes a number of tests, including two MRIs. He pays for these goods and services with his health credit card with no up-front payment and therefore is able to access the care he needs immediately, despite not having sufficient savings available to meet the costs up-front. The out-of-pocket costs for this treatment total \$900 and he receives a bill for this amount at the end of the month, with each individual service and its cost itemised. Josh's monthly after-tax income is \$3800 and therefore the minimum payment he is required to make for that month is \$380. Josh continues to pay the remainder of his \$900 bill in monthly instalments with no penalty as long as he meets the minimum payment.

By paying for health services with a health credit card, Josh is able to receive the care he requires immediately, his health care providers are paid promptly, and he is able to repay the cost of his care over time without causing him financial difficulties.

PROPOSAL 2: A SINGLE SAFETY-NET

A health credit card system could also be used to establish a single comprehensive safety-net for all health services to assist people who have difficulty meeting the cost of their care. This would replace existing Medicare and PBS safety-nets. It could be used to identify those people whose health care costs are abnormally high and address them through targeted measures. Currently, it is impossible to accurately target people who are unable to afford their health care costs⁴⁷. 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. The health credit card would help address a major data gap in this area and develop a comprehensive and targeted safety-net to replace the current system of uncoordinated and confusing safety-nets.

As a first step towards achieving this aim, all current health care safety-nets, such as the PBS and Medicare safety-net and the Medicare tax off-set, could be combined. 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. Different levels of subsidy could be applied to specific goods and services within the one safety-net – the most important factor is that all health care costs are combined within the one safety-net system.

Case study 6

Reuben and Sally each spend \$200 a month on their health care. However, Reuben's health care expenses are mostly for PBS-listed pharmaceuticals whereas Sally's are divided between GP visits, PBS medicines and physiotherapy. Under the current safety-net system, Reuben would reach the PBS safety-net after approximately 6 months and receive his medicines at a concessional price for the remainder of the year. However, Sally would not be eligible for the PBS safety-net and does not qualify for either the Medicare safety-net (as her out-of-pocket costs for medical services are not high enough) or the Medicare tax off-set (her overall out-of-pocket costs are not high enough).

By paying for health services with a health credit card, Josh is able to receive the care he requires immediately, his health care providers are paid promptly, and he is able to repay the cost of his care over time without causing him financial difficulties.

PROPOSAL 3: GREATER CHOICE FOR CONSUMERS IN PUBLIC HEALTH CARE

Our current system of public insurance and co-payments offers little or no flexibility to consumers in the way in which they contribute to the cost of their care. For example, all consumers receive the same Medicare subsidy for GP consultations and no consumer can be charged a co-payment for treatment as a public patient in a public hospital. Consumers can only receive Medicare funding for allied health care in specific situations and many other health goods and services receive little or no public subsidies. This approach does not take any account of consumers' different preferences for managing health care expenses or any variation in how they value different forms of health care or in their tolerance for risk.

While the government has little or no control over the fees set by providers and the costs of commercial health goods, it can improve the way in which public health care subsidies are delivered in order to give consumers more choice and more control over managing their health care costs. This can be done without compromising the goal of universality and equity of access to care and without creating unnecessary administrative complexities. A universal and publicly funded system should not mean a rigid and inflexible system but should seek to maximise consumer choice as far as possible in order to meet consumers' diverse needs, while supporting a more efficient use of health care resources.

Options for changing the way in which co-payments for health care are structured should focus on supporting consumers to choose the most cost-effective services and on addressing the gaps and inconsistencies within the existing system of co-payments. This could occur in a number of ways, including the following:

Option A Giving consumers the option of paying an excess for each non-emergency episode of public hospital treatment in return for receiving additional benefits, such as higher rebates for primary care services and/or goods and services currently not covered by Medicare or the PBS or lower safety-net thresholds⁴⁸. Excesses could be fixed at different levels with corresponding rebate levels for primary care services. This would allow consumers to share some of the risk of incurring hospital-related expenses

with the Government, while supporting the choice of consumers to access cost-effective primary care services. The current entitlement of all consumers to free public hospital care would be maintained.

Case study 8

Freya is pregnant and wants to have her baby in a public hospital. She is happy to share a room but would like to be able to choose her own doctor. She pays an additional fee to be able to choose her own obstetrician from whom she receives care during her pregnancy and who attends the birth of her baby (if required).

Angus is due to receive surgery to remove his gall bladder in a public hospital. He has no preference for which doctor will treat him however he would like to have a private room for the duration of his stay in hospital. He pays an additional charge to the hospital in return for receiving a private room.

By giving consumers the option of paying additional fees for services such as a private room or choice of doctor, the public hospital system can meet consumers' diverse needs without compromising equity of access.

Option B Allowing public hospitals the option of charging co-payments for additional (non-medical) services to patients, such as private rooms and choice of doctor (while maintaining the existing entitlements to treatment with no out-of-pocket costs). Currently, people who require these options are generally only able to obtain them within the private hospital system. This is unnecessarily restrictive and reduces the benefits to consumers of public hospitals. Allowing hospitals to charge co-payments for services such as this would give people increased choice within the public hospital system without compromising equity of access to care.

Case study 7

Kate chooses to pay an excess of \$500 per episode of public hospital treatment. As part of this 'risk sharing' arrangement she receives higher rebates for GP visits as well as subsidies for physiotherapy services.

Chris chooses to pay an excess of \$1000 per episode of public hospital treatment. As part of this 'risk sharing' arrangement he receives a subsidy for medical devices he requires, including a CPAC machine for his sleep apnoea.

The Morris family agree to pay an excess of \$1000 per episode of public hospital treatment. As part of this 'risk sharing' arrangement, they receive additional benefits for GP visits and a reduction in their safety-net threshold so they qualify sooner for additional subsidies.

These 'risk sharing' arrangements provide consumers with choice in the way they access health care subsidies and support a more efficient use of health resources by encouraging the use of lower-cost preventive care.

Option C Tying rebates to services rather than providers, so that consumers have the option of receiving care from alternative providers (where there is evidence that they can provide the services safely and effectively). For example, consumers could access services directly and receive Medicare rebates for specified medical services provided by nurses, nurse practitioners and other health professionals. Our current Medicare system focuses on providers, rather than the service provided, which supports a very rigid demarcation of roles within the health system and does not deliver maximum choice to consumers or represent the best use of health resources. By giving consumers the choice of health care provider for certain services, through changing the focus of Medicare from the provider to the service provided, the health workforce can evolve to better meet consumer needs and use health care resources more effectively.

Case study 9

Bettina would like a flu injection. As this service can be provided safely and effectively by either a GP or a practice nurse she is able to access the care provider of her choice and receive the same level of rebate from Medicare.

Toby is seeking cognitive behavioural therapy after experiencing a traumatic event. This service can be provided by either a GP trained in this area or a clinical psychologist. Toby receives a Medicare rebate, regardless of which provider he chooses.

Angela is expecting a baby. She has the choice of a community midwife or GP to provide pre-natal care. She is able to choose the provider that best meets her needs and receive the same subsidy for her care.

Linking rebates with services rather than providers gives consumers more choice and supports a more efficient use of health services.

Conclusion

Direct consumer contributions to health care provide almost 20% of total health funding and are an important factor in determining consumer access to health care. However, co-payments for health goods and services are developed and administered within a policy vacuum. Australia's current system of co-payments has evolved without any coherent objectives and without structured input from the community. This has resulted in an inefficient, overly complex and rigid approach to co-payments that does not meet the needs of either consumers or providers of health care.

A joint Commonwealth and State/Territory policy on consumer co-payments for health care, which reflects the community's views and promotes the use of the most cost-effective health care options, would make a significant contribution to the efficiency and equity of our health system. This should be developed following community consultation with input from other health stakeholders, such as providers, managers and policy-makers. Options for improving the current system of co-payments, such as those proposed in this paper, should be discussed within the context of this broader debate to ensure that changes reflect community values and preferences. Consumers, as both the users and ultimate funders of all health care, should always remain the central focus of debate on this issue to ensure that their interests (rather than those of the government or service providers) guide the development of co-payment policy in the future.

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1. AIHW 2008
 2. OECD 2008
 3. For example those proposed by the National Health and Hospitals Reform Commission in its Interim Report
 4. AIHW 2008
 5. Pharmaceuticals for which no PBS or RPBS benefit was paid and other medications. Includes: pharmaceuticals listed in the PBS or RPBS, the total costs of which are equal to, or less than, the statutory patient contribution for the class of patient concerned; pharmaceuticals dispensed through private prescriptions that do not fulfill the criteria for payment of benefit under the PBS or RPBS; and over-the-counter medicines including pharmacy-only medicines, aspirin, cough and cold medicines, vitamins and

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minerals, herbal and other complementary medicines, and a range of medical non-durables, such as bandages, bandaids and condoms.

6. Services provided by health practitioners (other than doctors and dentists). These include chiropractors, optometrists, physiotherapists, speech therapists, audiologists, dietitians, podiatrists, homeopaths, naturopaths, practitioners of Chinese medicine and other forms of traditional medicine, etc.

7. Comprises medical services funded by the Medicare Benefits Scheme, compulsory Motor Vehicle Third Party Insurance, Workers Compensation Insurance, Health Services Australia and from patient out-of-pocket payments.

8. Case studies included in this paper are hypothetical and used for illustrative purposes only

9. Medicare Australia (1)

10. Medicare Australia (2)

11. Australian Tax Office

12. Centrelink 2009

13. AIHW 2008

14. NATSEM 2008

15. For example, the MBF 'Premium Extras' policy has a \$300 annual limit of general dental benefits www.mbf.com.au

16. For a detailed discussion of the role of private health insurance within the Australian health system see Ian McAuley More than one health insurer is too many Centre for Policy Development 2008

17. Although this does not support the argument for extensive public subsidies for private health insurance as in the Australian health system

18. For example, in a speech to the Catholic Health Australia National Conference 2008 Health Minister Nicola Roxon described the Australian health system as "one of the most equitable and effective in the world." <http://www.alp.org.au/media/0808/speheag260.php> accessed 25 February 2009

19. Including all OECD countries with a per capita GDP of US \$30 000 or more

20. OECD Health Data 2008

21. However, the lower rate of co-payments within the US system, in combination with a lack of control over providers' fees, it is a major factor contributing to its higher overall health costs.

22. "For all households, the proportion of weekly household expenditure that went on health items was slightly higher for households living in rural Australia. This occurred across the range of health goods and services. This pattern of higher expenditure is maintained when only families that had health expenditure are analysed." NATSEM 2008

23. For a more detailed discussion of issues affecting rural health care see Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform: A discussion paper by John Humphreys and John Wakeman prepared for the National Health and Hospitals Reform Commission 2009

24. A Cystic Fibrosis Australia survey of people with CF found that adults without a Health Care Card incurred average annual expenses of over \$1600 for care related to their condition.

25. NATSEM 2008

26. Bobby Goldsmith Foundation 2008. The Foundation assists people directly disadvantaged by HIV and AIDS in NSW.

27. Chronic Illness Alliance 1997

28. Walker 2007

29. The Commonwealth Fund 2007

30. The Commonwealth Fund 2008

31. For example, Hynd et al found that co-payment increases for PBS medicines reduced consumers' ability to access essential medicines (Hynd et al 2008).
32. For example, the Bobby Goldsmith Foundation reports that resistance to HIV drugs can develop if people with HIV are unable to afford to take medication consistently
33. For example, in 2006 the (then) Federal Treasurer Peter Costello was reported as saying "the cost of the [PBS] scheme is rising each year faster than the economy grows and it is not sustainableit is important to find ways to reduce the amount the Government spends subsidising pharmaceuticals." ABC News
34. Austvoll-Dahlgren et al 2008
35. For example, Simon et al found that "modest visit copayments significantly reduced initial access to mental health treatment and had a smaller effect on treatment intensity. Copayments restricted access regardless of clinical need." Simon et al 1996
36. For example, to access the PBS safety-net consumers are advised to "keep a record of your PBS medicine on a Prescription Record Form (PRF), which you can get from your pharmacy. Each time you have a PBS medicine supplied, hand your form to the pharmacist so it can be recorded. Your pharmacy might be able to keep a record for you on their computer, but if they can't or if you visit different pharmacies, its best to keep your own records" Medicare Australia 2009
37. Department of Health and Ageing report Medicare Safety-Net Statistics 2006
38. Van Gool et al reported on the extended Medicare Safety-Net "These fee increases have resulted in considerable leakage of government benefits towards providers' incomes rather than reduced cost for patients.....For every dollar spent on the extended Medicare safety net last year, providers received 43 cents and patients 57 cents" Van Gool et al 2009
39. See McAuley I 2009 for a more extensive discussion of this issue
40. "We...want to see the overall balance of spending through taxation, private health insurance, and individuals' out-of-pocket contributions maintained." NHHRC 2008
41. For example a Federal Parliamentary Library research paper states "...most Australian opinion polls show public acceptance for higher taxes to pay for the popular broad-based items of health services and old age pensions." Research Note no.57 2003-04, *Less tax or more social spending: twenty years of opinion polling*, Richard Grant, Politics and Public Administration Section, 24 May 2004
42. More information on the role of citizens' juries within health care can be found in Mooney 2007 and Mooney 2008
43. In the June quarter 2007, an average of 12.3 Medicare-funded services were provided per Australian with considerable variability within this figure. For example, 3.2% of the population received 51 or more services each (accounting for 24.0% of total benefits paid) and around a third of the population received 1-5 services per person, accounting for 6% of the total benefits (AIHW 2008).
44. A similar idea was proposed by Laurence S. Seidman in "Health Card": *A New Prescription for National Health Insurance in Challenge*, Vol. 37, 1994. However, there are significant differences between this proposal and the approach suggested by this paper, in part due to differences between the Australian and US health systems. Seidman's proposal primarily focuses on achieving universal health insurance for all US citizens, a goal which has already been achieved in Australia.
45. The problems associated with using conventional credit cards to pay for medical treatment are discussed in Helaine Olen, "The Medical Credit Card Trap," *The American Prospect Online* accessed July 7 2009
46. A good overview of this issue is *One Way to Lower Health Costs: Pay People to Be Healthy* from Knowledge@Wharton www.knowledge.wharton.upenn.edu accessed 13 May 2009
47. As discussed above, research conducted by NATSEM and the Chronic Illness Alliance demonstrates that there is no direct relationship between level of income and difficulty affording health care.
48. Clearly this proposal and the changes recommended under Option B would need to be developed further in close consultation with the public hospital sector to ensure that there were no adverse impacts on the public hospital system overall or on individual hospitals.