

A road map for tackling out-of-pocket health care costs

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Abstract

The rapid growth in out-of-pocket (OOP) costs has undermined the universality of Medicare and the effectiveness of private health insurance. The increase in OOP costs means that many Australians delay or go without needed healthcare and/or access less appropriate alternatives. This impacts on all of us and reduces the efficiency of our health system. Despite growing awareness of the problems associated with OOP costs and their adverse impacts, there has been little effort by governments to address them. Due to the complexity of the Australian health system and the multiple ways in which consumers encounter OOP costs when accessing healthcare, there is no silver bullet solution to this problem. What is required is a multi-faceted approach with input and buy-in from all stakeholders, including governments at all levels, providers, industry and consumers.

This paper offers a road map for tackling the problems associated with OOP costs through short- and long-term initiatives, backed by evidence and informed by on-going consultation and evaluation.

Introduction

Healthcare costs are increasing worldwide, [in particular in middle and high income countries](#), due to a range of factors including the ageing of populations and new developments in treatments and technologies. If Australians want a healthcare system that delivers world class services and improved outcomes, we will need to accept that this will cost more and that this cost will be borne – directly and/or indirectly – by the community.

There is a number of different mechanisms through which our community can fund the health services we need. However, it is clear that progressive taxation is the fairest and most efficient funding mechanism for a universal healthcare system, delivering a high degree of both equity and administrative efficiency. We therefore believe that this should continue as the main source of funding for the full range of essential healthcare services required by consumers (including mental health, allied health, dental, eye and hearing, and medical aids and devices).

Direct individual contributions for health services (ie out-of-pocket costs) currently comprise [around 17% of total health care funding](#) and are the third largest source of funding after Federal and State/Territory governments. Out-of-pocket costs (OOPs) have some intrinsic disadvantages in that they impact disproportionately on those with higher healthcare needs and fewer financial resources. However, OOP costs have been a substantial funding mechanism within the Australian healthcare system over many decades and increases in OOP costs are often more politically palatable than taxation increases. Realistically we appreciate that this is likely to continue and that most Australians can expect to pay for at least some part of their healthcare via OOP costs in the future. But if OOP costs are to remain as a significant supplementary funding source, the focus must be on finding a fairer and more efficient approach to this component of health funding in order to avoid the serious problems and inequities resulting from the current system.

One reason why OOP costs present such a serious problem within our current health system is that they have been growing since the introduction of Medicare without any policy oversight or agreed goals for constraint. As a result, they have been imposed in an ad hoc and inconsistent way in different areas of the healthcare system. The level and type of OOP associated with health care [can](#)

[differ widely](#) from person to person, place to place and provider to provider, even for the same healthcare service, with little or no regard for patients' needs and ability to pay. For example, patients must pay out of pocket for every Medicare service that is not bulk-billed, for Pharmaceutical Benefits Scheme (PBS) co-payments, for private health insurance (PHI) premiums and for those costs in the private hospital system that are not covered by their PHI, for treatment for mental health and substance misuse problems. Most Australians must also pay the majority of costs for their dental care, allied health services and optical and hearing services. Many will have costs resulting from over-the-counter medicines and expendables needed to manage diabetes, colostomies, incontinence, pressure sores and ulcers (*A summary of recent data on OOPs in the Australian health system is at Appendix 1*).

For the chronically ill and disabled, these costs – already substantial – are in addition to costs for special equipment such as wheelchairs, home modification and transport, and assistance with the activities of daily living. OOPs compound the already significant disadvantage experienced by the [poorest Australians who are the sickest](#) and most likely to face financial barriers to their ability to access the services and care they need.

This results in a range of equity and efficiency problems and in some cases has created two-tiered access to healthcare, where people with money get ready access to services and those without, go without, [regardless of their need](#). The consequences of the access barriers created by OOPs are significant – in terms of health status, productivity, community engagement, quality of life, and dollars – for individuals, their families and carers, communities and governments. In fact, some experts have suggested that out-of-pocket costs are [as important a side effect of health care](#) as physical responses to treatment and that therefore advice about the cost implications of treatment should be included in the information given to consumers prior to receiving care.

There has been [growing concern](#) about this issue for many years among consumer groups and other health stakeholders. In 2018 [a survey of 1200 people](#) undertaken by the Consumers Health Forum of Australia found that one in six people reported that health care costs had a significant impact on their lives, with some having to draw down on their superannuation to pay for needed care. Well over one third of respondents said that no-one had discussed the possibility that they may face significant out of pocket costs with them and that they had the right to shop around.

There is no silver bullet to fix this problem. Problems arising from the ad hoc and uncoordinated application of OOP costs mean that they affect almost all consumers at some point and arise in all sectors of the healthcare system. Despite these significant impacts on consumers, there has been little substantive action on this issue by governments. Throughout its tenure the current Coalition Government has evinced no concern for the erosion of the universality of Medicare and the undermining of the public healthcare system, which has contributed to the cost burden on consumers. Indeed, it has proposed a number of policies (such as increased copayments, a freeze on Medicare rebates, and funding cuts to payments to states for public hospitals) which would aggravate the situation.

Private health insurance (PHI) is not a solution to the problems with OOP costs, despite the fact that successive Coalition governments (and the health funds themselves) claim that this is the case. PHI does not protect consumers from unexpected and open-ended hospital costs and in many cases it pays only a fraction of the cost of dental and allied health services. Some services (such as mental health) may be excluded from PHI cover. Many [consumers with PHI report](#) that they are unable to access the services they need because they are unable to afford the upfront payments required.

Existing safety-nets, such as the [PBS safety-net](#) and the [Medicare safety-net](#), are also not effectively addressing the problems associated with OOPs. While these mechanisms reduce the cost of some forms of health care for some consumers, they are poorly designed and do little to help the less well-off. This is because they require significant up-front payments before they come into effect and therefore do not address the needs of people on low incomes who must limit their access to medical and dental services and medicines well before the safety net limits are reached. They are also restricted to expenses incurred within each program (the PBS and Medicare) and do not capture the overall impact of health care costs on consumers across all areas of care. These safety-nets have been endlessly [tinkered with](#) other the years, but currently the [main benefits](#) accrue to high income patients and high-charging specialists.

The federal government looks to the viability of PHI funds, pharmacies and the pharmaceutical industry, and doctors and dentists have [specific constitutional protections](#), but there is no part of the federal Department of Health that is charged with addressing the financial impacts of healthcare policies and funding on the people for whom they are designed – the general population trying to stay fit and healthy and the patients who are sick or injured. That needs to change.

Tackling OOP costs in ways that are equitable and evidence-based will require a multi-faceted approach that includes effective incentives and enforcement provisions. It must necessarily involve the best efforts of all the players – politicians and bureaucrats at all levels of government, the medical, pharmacy, dental and allied health professions as organisations and individuals, private health insurers, the businesses that supply healthcare products and services, and consumer and patient organisations. Most importantly, it will require brave leadership from those who can implement and then monitor the necessary changes.

What this paper offers

Three years ago, we wrote a discussion paper on [Tackling Out-of-Pocket Health Care Costs](#) that outlined the issues and offered a number of recommendations for action. Almost all those recommendations remain valid today; this paper updates and adds to them in the light of new reports, data and information (*these are summarised at Appendix 2*). It provides a road map, with a focus on short- and medium-term actions that will make a difference and move towards the long-term goals.

The problem of OOP costs is multi-faceted and thus requires a range of solutions. These need to be developed and implemented in conjunction with each other as focusing on a single area of healthcare can result in unintended consequences, including growth in OOP costs in other areas. It is also important that approaches to reducing OOP costs are reviewed regularly to identify and address any unintended negative impacts.

Actions must start now, even in the absence of all the needed information and data; that can be collected, evaluated and addressed as work proceeds.

How to get there – recommendations for action

Identifying long-term goals

The starting point for tackling OOP costs should be agreement on the overall aims and guiding principles for their (constrained) role within the Australian healthcare system. These should take account of the fact that Australia will need to spend more on healthcare in the future to maintain our world class healthcare system, but also recognise that evidence- and value-based expenditures on health are investments that deliver reductions in costs elsewhere in the healthcare system and in the federal budget. This will involve choices about how healthcare funding is raised (eg taxation and levies), about what are considered essential vs non-essential services, about which healthcare costs we share with others (eg via Medicare or PHI) and which costs must accrue to individuals.

The principles should include the following:

1. OOP costs (for individual services, episodes of care, and ongoing treatments) should not be a financial barrier to accessing essential healthcare.
2. OOP costs should promote the efficient use of healthcare.
3. Adequate safety-nets should be established to ensure vulnerable individuals and groups (eg. people on low incomes and those who are high level users of services) are protected from OOP costs and not discriminated against.
4. Data should be collected on OOP costs across the healthcare system and used to inform policies and strategies. There must be recognition of the cumulative impact of these costs and also that some people do not incur any OOP costs because they are so financially disadvantaged that they never present for needed care.
5. Consumer experience should be at the centre of policy development to address OOP costs.

Ultimately we believe that the idiosyncrasies of the Australian healthcare system - which places no constraints on prices charged by healthcare professionals for services which attract a Medicare rebate, which is hamstrung in efforts to address the maldistribution of the healthcare workforce by a constitutional provision, which has allowed the majority of some surgeries (eg cataracts) to be performed in the private hospital system, and which provides billions of dollars annually in subsidies for PHI which the majority of Australians do not have and even fewer want - must be addressed.

These are controversial and major reforms, the lack of which should not stand in the way of immediate moves to tackle OOP costs.

Identifying specific groups at risk

In developing policies and strategies to reduce the negative impact of OOP costs within the healthcare system, the specific needs of consumers particularly affected by these costs should be considered. These include:

- People on low incomes;
 - People with chronic and complex conditions;
 - People who face a catastrophic health event, even where the impact is time-limited;
 - Families where more than one person has a chronic or complex condition and / or disability;
- and

- People in areas that are isolated and / or medically under-served.

It is also important to take into consideration the findings of quantitative analyses (such as that provided in the recent [Australian Institute of Health and Welfare report on Medicare OOP costs](#)) which identifies significant variations in OOP costs around the nation, and qualitative research (such as the [Out of Pocket Pain report](#)) which identifies key areas in which consumers report problems with OOP costs. These include:

- Chemotherapy;
- Mental health;
- Allied health;
- Non-PBS medicines; and
- Travel and other non-health expenses associated with care.

Over-arching issues

There are three over-arching issues that must be addressed to ensure that the issues around OOP costs and their impacts remain a central focus of the healthcare system:

1. A designated division within the Department of Health with responsibility for patient and consumer issues

In a patient-centred healthcare system, the viewpoints, needs, concerns and involvement of patients and consumers should be a given. While approaches on this front are improving, there is still a long way to go, and the patients' / consumers' voices are often not heard or are drowned out by those of other stakeholders. Given the extent to which OOP costs contribute to the operation of the Australian healthcare system, patients and consumers are deserving of the same bureaucratic attention as the pharmaceutical industry, the PHI funds and organized medicine and other clinical professions. A specific area within the Department to oversee and coordinate policies affecting consumers across different areas of the healthcare system, would give issues such as OOP costs greater visibility and support coordinated and evidence-based policy responses.

2. A system for resolving complaints about OOP costs and disagreements about medical fees

An [MBS Review recommendation](#) is for the development of a non-adversarial system for resolving complaints about OOP costs and disagreements about the fees charged. There are bodies established to handle health outcome, quality and malpractice complaints, but there is no independent body to handle complaints about the failure to provide financial consent, or that allow consumers to report issues regarding costs of services. Given the findings on the [geographical and craft group variation in medical fees](#) and the lack of data to support a link between the level of fees charged and the quality of the service, it is important that consumers are educated and empowered to make informed choices about their providers and to seek redress when informed financial consent was not obtained or excessive fees have been charged.

3. Ethical responsibilities of healthcare professionals who receive Medicare funds

To the extent that OOP costs are the result of egregious over-charging and fee manipulation, consideration should be given as to whether healthcare professionals who are shown to continually engage in this conduct should continue to be entitled to receive Medicare funds via the patient rebate. This is a contentious issue – one which is easier to deal with in an environment where there is greater certainty about the appropriateness of the Medicare Benefits Schedule fee – but it is the source of an inherent tension in the Medicare system between a private business model and government funding.

The [French model](#), where there is an agreement signed between physicians' unions and the government to limit OOP costs, might well serve as a model. In exchange for cost capping, there are reduced social charges (taxes and healthcare levy) for doctors. France has also managed to integrate public and private health insurance without inflationary impacts.

Strategies and solutions – and linking these to tackling specific problems.

The following section identifies some of the specific issues that generate OOP costs and recommends short and longer-term strategies to address them. Details explaining these recommended strategies in more detail follow. This does not purport to be a definitive list of either problems or solutions, but rather it should be seen as a starting place for action and further consultation and policy development.

Specific problems associated with OOP costs

OOPs should not be seen as a single issue but rather as a suite of overlapping problems which can reinforce and sometimes compound the problems associated with each one of them. This section identifies the main problems associated with OOP costs and which of the specific strategies (outlined in the section below) are best suited to address them.

Problem: High GP OOP costs

Short-term solutions: Fee disclosure website; Reconsider the GP gatekeeper role.

Longer-term solutions: Implementation of recommendations for general practice and primary care from MBS Review; Improve workforce distribution; Better utilisation of the health workforce to ensure health professionals such as paramedics, pharmacists and nurse practitioners are working to their scope of practice; Tackling over-testing and over-prescribing, including medication management reviews; Establishment of community health centres with salaried staff; Research to understand reasons why GPs bulk bill / do not bulk bill.

Problem: High specialist OOP costs / over-charging (outpatients)

Short-term solutions: Fee disclosure website; Incentives for specialists to bulk bill / reduce fees; Require specialists' colleges to address egregious over-charging; Strengthened informed financial consent requirements; Limits on requirements and charges for MBS item 104.

Longer-term solutions: Implementation of recommendations from MBS Review; Improving workforce distribution; Commonwealth / State funding for specialist out-patient clinics; Better utilisation of para-medical workforce; Better shared care and case conferencing with specialists / GPs/ allied health professionals; Tackling over-testing and over-prescribing; use of generalists to provide wholistic care for patients with multiple co-morbidities; Research to understand what drives substantial fee variations.

Problem: High specialist OOP costs / over-charging (inpatients)

Short-term solutions: Fee disclosure website; Incentives for specialists to bulk bill /reduce fees; Require specialists' colleges to address egregious over-charging; Strengthened informed financial consent requirements; Requirements on PHI funds to provide full details of what policies cover and the type and extent of likely gaps; Increased use of midwives; Oversight by of administration and booking fees; No interest / low interest loans to cover unexpected costs.

Longer-term solutions: Implementation of recommendations from MBS Review (especially with respect to anaesthesiology and orthopedics); More procedural GPs; Tackling low-value procedures and treatments and over-use of caesarian sections; Bundling of fees for pre-hospital, surgical, post-hospital / rehabilitation procedures; Research to understand variations in billing and fees.

Problem: Consumers with multiple chronic conditions resulting in high ongoing OOP costs from multiple sources

Short-term solutions: Comprehensive healthcare safety-net; Incentives for specialists to bulkbill/reduce fees; Reconsider the GP gatekeeper role; Payment structure for enable GPs to provide allied health services; More public dental and allied health services; More public out-patient mental health services; More funding for patient transport and related services; Expand ability to access PBS concession card; Better provision and coordination of transfers of care.

Longer-term solutions: : Implementation of recommendations for general practice and primary care from MBS Review; Commonwealth / State funding for specialist out-patient clinics; Better utilisation of para-medical workforce; Better shared care with specialists / GPs/ allied health professionals; Tackling over-testing and over-prescribing; Use of generalists to provide wholistic care for patients with multiple co-morbidities; Active case management and improved health literacy; Development and roll-out of Patient-Centred Medical Homes model/s; Establishment of community health centres with salaried staff; More sub-acute (physical and mental health), rehabilitation and palliative care services.

Problem: Inadequacy, inappropriateness of Medicare rebates in some areas

Short-term solutions: Increased efforts to update Medicare Benefits Schedule.

Longer-term solutions: Implementation of MBS Review recommendations already made; Research to identify areas where new techniques and technologies have changed practice; Recognition of the need to reward cognitive services better.

Problem: Unexpected and unaffordable costs in the short-term (for example: due to an accident)

Short-term solutions: Comprehensive health safety-net; No interest /low interest loans to cover unexpected costs; Expansion of social welfare payments to cover period of illness and rehabilitation; Increased availability and affordability of necessary aids.

Longer-term solutions: Commonwealth / State funding for specialist out-patient clinics; Ability to access approved package of Medicare-funded rehabilitation services.

Problem: People delaying or forgoing preventive services due to cost

Short-term solutions: Comprehensive health safety-net; Fee disclosure website; Incentives for specialists to bulk bill/reduce fees; Vouchers for accessing preventive care in the private system; Reconsidering the GP gatekeeper role

Longer-term solutions: Increased provision of public sector specialist services; No/low interest loans for high cost health care expenses; more public dental and allied health services; Active case management; Strengthening the role of generalists; Establishment of community health centres with salaried staff

Strategies and solutions

1. Fee transparency via a fee disclosure website

An online resource should be established with mandatory disclosure of fees by medical practitioners. This resource should be promoted broadly and accessible to a diverse audience. Any additional non-medical fees (such as 'booking' or 'administrative' fees) should also be included in the website and penalties (such as removal of Medicare entitlements) should be imposed for non-compliance. Consumer education about medical fees should be developed and implemented in association with the website (see below).

2. Re-consider the GP gatekeeper role

GPs play an important role as gatekeepers within the Australian health system. In general this role works well and reduces overall health care costs. However, there may be scope to exempt some specific services from this role in some instances and/or to delegate this role to other healthcare providers such as practice nurses or pharmacists.

Recent research found that most patients request certificates, medications and referrals in the context of seeking help for other health needs, but 7.4% of encounters were potentially only for low value / administrative care. Some areas where changes could occur include: routine repeat prescriptions; routine renewal of specialist referrals; and referrals to 'generalist specialists' such as paediatricians and geriatricians.

This is in line with recommendations from the MBS Review about the 'stewardship' role of GPs and how this strengthening this might change the need for face-to-face encounters for at least some patient requests for renewal of prescriptions and referrals and communication of results.

3. Incentives for specialists to bulk bill / reduce fees

There currently are no incentives for providers to bulk bill referred medical services (apart from pathology and diagnostic imaging). Targeted incentives payments could be made to specialists to encourage bulk or low fee billing. This could be directed to areas (both geographical regions and areas of medial speciality) in which there are few bulk/low billing specialists. Information on the availability of no/low fee billing specialists should also be provided to consumers to ensure they are aware of this option.

4. Require specialists' colleges to address egregious over-charging

While specialist colleges like the Royal Australian College of Surgeons have spoken out about outrageous fees and said: "We as a professional body need to remediate our members who feel

they are entitled to charge fees that are silly. That’s our responsibility.”, there is no evidence that this happens in practice. In the absence of a formal system for resolving complaints, reporting problems to specialist colleges remains one of the few avenues patients have to resolve issues around excessive OOP costs.

5. Strengthened informed financial consent (IFC) requirements

A number of changes can be made to improve IFC processes which empower consumers to seek better value care. These can include: single billing for services which require more than one provider (eg surgeon and anaesthetist); a requirement that all fees (including so-called administrative and booking fees) are disclosed prior to the provision of the service; mandatory disclosure of high OOPs for providers charging more than a designated amount above the schedule fee (e.g. 120%); changes to GP referral guidelines to make clear that consumers have a choice of specialists in that area (such as putting the specialty rather than the individual specialist first on a referral form and including the names of more than one provider); and consumer education about health care cost issues.

6. Limits on requirements and charges for MBS item 104.

MBS item 104 is an initial referral from a GP for specialist services. The [Department of Health guidance](#) states that “A new referral may be provided for the same condition(s) and does not necessarily indicate that another initial attendance item should be billed.” However many, if not most, specialists require a new referral (even for the same condition) at least every 12 months and bill for this – often at a level significantly above what MBS reimburses and what the [AMA recommends](#) (which is twice the MBS fee). This poses an immediate financial barrier for many patients.

7. No interest / low interest loans to cover unexpected costs.

Where consumers have difficulty affording a short-term, high healthcare expense (such as an unexpected surgery) they should be able to obtain no/low cost loans to repay the cost over the longer term. This should assist consumers who have the capacity to contribute to their healthcare expenses over the longer term but are prevented from doing so due to short-term cash flow issues. For example, someone on a low or fixed income needing a joint replacement may not be able to afford the upfront costs but may be able to pay the OOP costs associated with this service in the private sector over a 3-year period. Rather than waiting for three years to save this money (with the associated deterioration in the condition) they could receive an no/low interest loan to access the service straightaway and pay the cost back over time at a rate that is affordable to them.

8. Increased provision of public sector services

(a) Specialists

Increasing the number of specialists in the public system, particularly in geographic and speciality group areas of need, would give consumers more choice and add to competition with specialists in the private sector, thus putting downward pressure on their fees. This could be achieved via State and Commonwealth cooperation on establishment and Medicare funding for specialist out-patient clinics (bulk billing or more innovative funding approaches). As this would take pressure off the private sector it could be funded at least partly from the PHI rebate.

(b) Dental and allied health services

Dental and allied health services are nominated by consumers as key sources of OOP costs. Increasing the provision of public dental and allied health services (at a low cost to consumers) would give consumers on low incomes access to these services and provide competition with the private sector to reduce overall costs. These services should target areas where preventive care can improve outcomes and reduce costs, for example, preventive dentistry for people on low incomes.

They could be provided via hospital out-patient facilities, in primary health care centres and/or community health centres. Different funding models would be required for each service.

(c) Mental health services

The funding and development of mental health services in the community is inadequate to meet the growing needs. The prevailing reality of 'community-based care' is limited, ad hoc and clinically focused. Many services are being colocated with hospitals or provided out of hospitals, rather than in community settings. [AIHW data](#) for community mental health services for 2016-17 highlight the problems in access. Mental health is the [most common ailment](#) of GPs' patients but for many treatment (from a GP, psychiatrist or psychologist) is a [luxury they cannot afford](#).

9. [Payment structure for enable GPs / Health Care Homes to provide improved access to allied health services](#)

Currently Medicare supports limited access to allied health services, which are generally provided for patients under a GP-managed chronic disease or mental health plan. Ancillary private health insurance plans will pay for some allied health services, but this is generally a capped rebate. Allied health professionals have repeatedly pushed for increased Medicare access, but the provision of new MBS items would only exacerbate the issues of OOP costs. An alternative funding model could be developed that would enable general practices and Health Care Homes to employ allied health professionals and bill Medicare for the services they deliver, with low or no OOP costs.

10. [More funding for patient transport and related services](#)

Health related travel costs are not accounted for when health expenditure data is collected. Evidence provided to a [Senate Committee in 2014](#) indicated that health-related travel costs make a significant contribution to individuals' OOP costs and can act as a barrier to accessing needed care. These costs include direct travel costs (flights, train or bus, fuel), hospital parking, and accommodation.

11. [Better provision and coordination of transfers of care.](#)

A drive towards better integration and coordination of care, especially when patients transfer from one healthcare sector to another (e.g. from hospital to rehabilitation or home; from aged care to hospital) will improve the quality of care and quality of life for patients. Doing [transfers of care](#) better will also mean reductions in duplication of care and the associated costs.

12. [Comprehensive health safety-net](#)

Where OOP costs exist within the healthcare system there will always be a group of consumers who have problems affording these costs. Therefore, an adequate safety-net is important. Current safety-nets are poorly designed and fragmented as they address only single areas of OOP costs (eg PBS or Medicare) and only cover costs over a defined period (usually 12 months). They also require people to pay the full OOP cost for each service until a defined threshold is reached which is a barrier to access for some people.

A comprehensive health safety-net should be established which initially combines the MBS and PBS safety-nets and (over time) builds in dental and allied health and other health expenses (such as medical devices). This should be targeted specifically at people who have difficulty affording healthcare costs over the long term, but also address short-term affordability problems such as those that arise because of an accident or serious (but time-limited) illness.

Consideration should be given to different safety net thresholds for different groups of patients, based on need, income, health prognosis and disability level.

13. Vouchers for accessing care in the private system

In specific areas where there are unusually long delays in accessing services in the public system, and where these delays will result in more serious health problems and adversely affect quality of life for consumers (e.g. dental problems, joint replacements, cataract surgery) vouchers could be provided to enable public patients to access specific services in the private system.

14. Active case-management

For consumers with complex needs and high OOP costs, a targeted approach involving active case management and care coordination by a GP (or in some cases another healthcare professional) may be warranted. This would involve registration with a practice and a bundled payment provided with flexibility for the allocation of this payment across providers/services. This would help reduce OOP costs in the following ways:

- Patient incentives to register could include the removal of co-payments and / or subsidies for OOP costs.
- Better continuity and coordination of care will potentially decrease duplicate tests and low value care.
- Increased scope for prevention should reduce long-term need for care and thus reduce OOPs

Savings resulting from reduced testing and hospitalisation would off-set the costs of subsidising OOP costs for this group of patients.

15. Better utilisation of para-medical workforce

Currently, Australia does not make optimum use of practice nurses, mental health (and other specialty) nurses, community and Aboriginal health workers, midwives, nurse practitioners, pharmacy assistants, paramedics, dental technicians and dental hygienists.

These healthcare professionals can all provide important services within their scope of practice which will reduce the demand for GP, specialist and dental care. Funding models to support them to play a greater role, in particular for the provision of services to people with chronic and complex conditions, should be developed. These should include models that do not rely on fee-for-service as that has not proven to be an optimum funding mechanism for services to this group of consumers.

16. Strengthening the role of generalists

One factor contributing to high OOPs costs for people with complex conditions is the need for them to see multiple healthcare providers. Strengthening the role of generalist medical practitioners in key areas could consolidate their care, thus improving coordination, reducing the number of services needed and thus reaching OOP costs. Key areas in which this could occur include procedural general practice (in particular in rural areas) and more 'generalist speciality' areas such as paediatrics and geriatrics.

Given the [growing numbers of people with multiple comorbidities](#) and the need to treat such patients as an individual rather than a series of individual diagnoses, this should deliver improved health outcomes.

17. Establishment of community health centres with salaried staff

There is strong support among most stakeholders (if not organised medicine) for the establishment of community health centres with salaried staff in medically under-served and lower socio-economic status areas. These would be similar to the current Aboriginal Community Controlled Health Organisations or the [US model of community health centres](#).

Such centres are extremely effective at meeting local needs and addressing health inequalities. A decreasing number of such centres, funded by the states, exist. However in this case the proposal is for Commonwealth funding on the basis of local needs and disease burden, with a bundling of MBS and PBS funds. There could be a requirement for contributions from States and Territories as they would arguably benefit from reduced Emergency Department attendances and hospitalisations. A key requirement would be that there are no co-payments or deductibles for patients.

It is anticipated that there are doctors who would welcome the opportunity to work in such centres, which have the potential to offer all that is needed for primary health care, with the integration of health and social services. Employment could be made more attractive by offering recent health care graduates the possibility of reducing their education debts. It is critical that the establishment of these centres is managed in conjunction with GPs and other health care providers in the local area to ensure that they address an unmet need for care rather than duplicate existing services. These centres would not address the problems with OOP costs for all consumers but could provide a partial solution in areas in which high OOP costs are driven by workforce shortages.

18. Tackling over-testing and over-prescribing and low value care

Reducing low value care would reduce OOP costs as well as make better use of health resources by directing them towards higher value services. There are already initiatives in place to reduce low value care, for example, the Choosing Wisely program and other initiatives of NPS Medicinewise and the work of the MBS Review. These could be strengthened, in particular in areas which generate OOP costs. For example, financial incentives could be provided for prescribers to engage in peer-based education and feedback on prescribing patterns. Additional measures targeting low value services funded via PHI should also be implemented, for example, the removal of the 30 percent rebate for services provided that are considered low value.

19. Improving workforce distribution

Workforce distribution can play an important role in influencing OOP costs. For example, there are some clear patterns showing that bulk billing is higher in areas of high doctor density. A more equitable workforce distribution would therefore support a more equitable distribution of OOP costs across the population. This could be achieved through the introduction of geographical provider numbers or other restrictions on where doctors can practice (for example, limits on the number of provider numbers available in areas of over-supply or lower rebates for areas in which there are more doctors than necessary).

Conclusion

The problem with OOP costs has been developing for decades and will take time and collaborative effort to unravel. A combination of short- and longer-term strategies is required, targeting key problem areas and consumer groups particularly affected by the growing burden of OOP costs. Due to the complexity and the self-adapting nature of the health system, strategies will need to be regularly reviewed to assess their impact and adjusted where they are found to have resulted in unintended adverse impacts. Implementing individual strategies without taking into account their impact on other areas of the health system could lead to the creation of larger (and more expensive) problems elsewhere.

The starting point for addressing OOP costs needs to be agreement on their role and purpose and some common understanding of the principles which inform their implementation. Underpinning this process should be comprehensive data collection which reveals the OOP costs burden across the spectrum of the healthcare system and can be used to assess the outcomes of interventions.

In the short-term, significant progress can be made by through identifying and addressing 'outlier' issues, such as the minority of practitioners charging excessively high fees and those consumers most at risk of high health care costs. However, this is only one manifestation of the problem. Over the longer term, the greatest gains will be achieved by making structural changes to the funding and delivery of healthcare which address a wider range of issues associated with OOP costs, for example, through supporting workforce reforms to increase the cope of professionals and to strengthen the provision of medical specialist care in the public system.

An update on out-of-pocket costs

Out-of-pocket costs continue to escalate

The [most recent data](#) from the Australian Institute of Health and Welfare (AIHW) show that in 2016-17 spending by individuals was 16.5% of total healthcare expenditure (\$29.8 billion of \$180.7 billion). This is 60.3% more than they spent in real terms in 2006–07 but down slightly as a proportion of total funding from 17.1% in 2015–16. Given that OOP costs for individuals have risen during this time, it is quite possible that this national drop represents the fact that increasing numbers of people are going without healthcare services due to cost.

The AIHW report highlights where this expenditure occurred: the largest cost was \$9.4 billion for non-subsidised medicines, followed by \$5.7 billion for dental services (see Table 1)

Table 1: Areas of expenditure for OOP costs

Area of expenditure	Total OOP expenditure
PBS subsidised medicines	\$1.3 billion
All other medicines	\$9.45billion
Unreferred medical services (ie GPs)	\$0.8 billion
Referred medical services (ie specialists, diagnostic services)	\$3.0 billion
Other health practitioners	\$2.2 billion
Hospitals (public and private)	\$3.2 billion
Dental	\$5.9 billion
Aids and appliances	\$2.9 billion

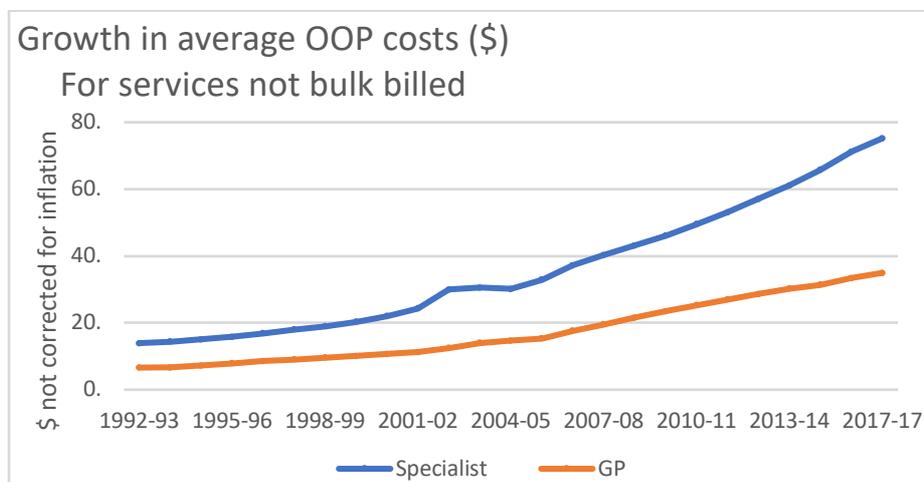
The FY 2017-18 [annual report on Medicare statistics](#) shows that there has been little change in bulk billing rates for Medicare services in recent years, but OOP costs for those services not bulk billed continue to escalate. There are no data to highlight how the Medicare freeze has impacted bulk

billing by GPs, but [anecdotal evidence](#) suggests that it has been increasingly difficult for doctors to continue bulk billing and those charging gap payments have increased these.¹

Figure 1 highlights the burgeoning growth in OOP costs for GPs and specialists; the increasing rates observed from 2005-06 are likely due to the recognised inflationary impact of the introduction of the Extended Medicare Safety Net (EMSN). The various changes made to rein in the cost to the budget of the EMSN appear to have exacerbated the rate of increase of OOP costs for specialists.

The [Medicare quarterly statistics to June 2016](#) show OOP costs for all Medicare services have increased by 25.1% since September 2013. Over the same period, OOP costs for specialist appointments are up by 29.7%.

Figure 1: Growth in OOP Costs for GPs and Specialists



Data from [Annual Medicare Statistics reports](#) released by Department of Health

There are startling disparities in out-of-pocket costs across Australia

The importance of using granular methodologies to look at where OOP costs have the biggest impact is highlighted by the recent report from the AIHW report *Patients' out-of-pocket spending on Medicare services, 2016-17*. This report looks only at OOP costs only for Medicare-subsidised healthcare delivered outside a hospital, and analyses these by geographical areas (Primary Health Networks (PHNs) and Local Government Areas (LGAs)).

In 2016-17, 50 percent of patients (some 11 million people) who received at least one Medicare-subsidised service in the community (who saw a GP or a specialist or who had a diagnostic or pathology test) had the full costs covered (ie they were bulk billed); the remainder paid something

¹ Indexation for bulk-billing incentives for GPs re-commenced 1 July 2017; standard consultations by GPs and specialists were then indexed from 1 July 2018; specialist procedures and allied health services will be indexed from 1 July 2019.

out of their own pocket for these services. In total this amounted to \$3 billion, while governments' spending in this area was \$19 billion.

There was considerable variability in the rate of bulk billing, ranging from 69 percent in the Northern Territory to 31 percent in the Australian Capital Territory.

For the 11 million people who had costs, the median annual OOP cost was \$142 but 5.5 million people spent more than that and 1.1 million patients spent \$601 or more. The variations across both Primary Health Networks (PHNs) and local areas (SA3s) in spending at the fiftieth percentile (median) and ninetieth percentile (top 10 percent) showed some correlation with socio-economic status (SES) but not enough to indicate that the majority of poorer Australians were protected from OOP costs.

Not surprisingly, patients were more likely to have OOP costs for specialist and obstetric services, with 72 percent of patients incurring costs for specialist services and 42 percent for obstetric services. These services also attracted the highest out-of-pocket costs per service.

One third of patients had costs for GP services – a fact concealed in the Government's touting of bulk billing rates. The median cost for a specialist service was \$64, but the 90th percentile paid \$137 or more per service. The median cost for an obstetric service was \$78 and for the 90th percentile it was \$399 or more. The median cost for a GP service that was not bulk billed was \$20 and people in the 90th percentile paid \$42 or more.

The report highlights some startling disparities. For patients with OOP costs, the total amount spent by the 10 percent of patients with the highest costs ranged from at least \$432 in the Murray PHN to at least \$876 in the Northern Sydney PHN. While a greater proportion of patients had OOP costs in regional PHNs than in metropolitan PHNs, patients in metropolitan PHNs areas tended to have a higher spend. Some evidence suggests that the higher costs in high SES metropolitan areas is due to a combination of high fees and a greater number of services – an indication that the inverse care law is in effect.

There is somewhat better evidence that in some lower SES areas, doctors attempt to limit patients' OOP costs. Some of the evidence for this comes from considering the breakdown of data by SES in metropolitan areas (see Table 2). There is less evidence for this altruism outside of metropolitan areas; presumably this reflects workforce maldistribution.

Table 2: the relationship between patients' socio-economic status and OOP costs

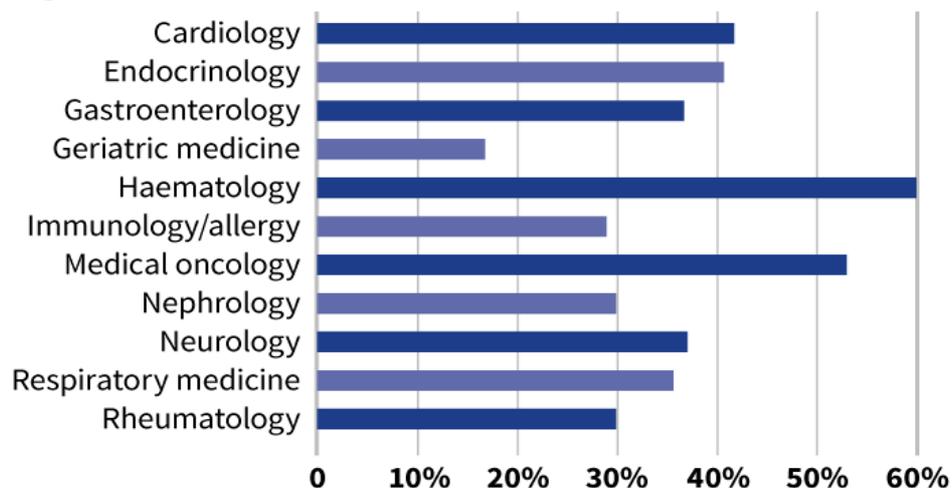
Metropolitan SES	GPs / service			Specialists / service			Obstetrics / service		
	% w OOP costs	50 th percentile	90 th percentile	% w OOP costs	50 th percentile	90 th percentile	% w OOP costs	50 th percentile	90 th percentile
High	48.0	\$25	\$48	79.5	\$77	\$155	62.8	\$167	\$508
Medium	30.3	\$18	\$40	73.2	\$65	\$137	43.4	\$114	\$391
Low	19.1	\$15	\$37	64.9	\$60	\$127	30.5	\$129	\$399

High specialists' fees are a particular problem

A seminal paper from [Freed et al](#) published in the Medical Journal of Australia in March 2016 highlighted the low bulk billing rates by non-surgical specialists and the huge variations in OOP costs.² This paper was especially valuable because it looked at the proportion of initial consultations (billed at MBS item 104) which were bulk billed (see Figure 2).

Figure 2

Proportion of first consultations with a specialist that were bulk billed in 2015



Source: MJA

From Medew J. Seeing a specialist: how variations in fees are hidden from patients. Sydney Morning Herald, 16 March 2016 <http://www.smh.com.au/national/health/seeing-a-specialist-how-variations-in-fees-are-hidden-from-patients-20170305-gur2kh.html>

For too many patients the cost of an initial consultation to see a specialist is a significant financial impost. The MBS fee for this is \$85.55, of which the patient is reimbursed 85%, however many specialists charge dramatically more. The gap between what Medicare pays and the AMA-recommended fee for MBS item 104 (it was \$166 in 2016) is now around \$100 and evidence from family and friends indicates that it is not unusual for the gap to be more than this. The rate of specialist bulk billing also varies geographically, with highest rates in the Northern Territory (around 75%) and lowest rates in Western Australia (less than 20%). Moreover, these payments vary substantially within specialties (see Table 3).

² Note that this MJA paper is behind a pay wall, so we will reference instead a report and data provided in the mainstream media.

Table 3: Out of pocket costs charged by specialists in 2015

	Mean	Median	10th percentile	90th percentile
Cardiology	\$73.70	\$66.90	\$22.60	\$126.70
Endocrinology	\$94.70	\$85.10	\$31.70	\$171.70
Gastroenterology	\$75.70	\$66.90	\$31.70	\$131.70
Geriatric medicine	\$56.70	\$58.30	\$22.60	\$85.10
Haematology	\$85.70	\$71.70	\$22.60	\$156.70
Immunology/allergy	\$128.70	\$141.70	\$51.70	\$176.70
Medical oncology	\$67.70	\$65.55	\$22.60	\$111.70
Nephrology	\$67.70	\$66.70	\$22.60	\$111.70
Neurology	\$123.70	\$121.70	\$22.70	\$211.70
Respiratory medicine	\$82.70	\$71.70	\$31.70	\$141.70
Rheumatology	\$107.70	\$111.70	\$46.70	\$171.70

Source: MJA In Medew J. Seeing a specialist: how variations in fees are hidden from patients. Sydney Morning Herald, 16 March 2016 <http://www.smh.com.au/national/health/seeing-a-specialist-how-variations-in-fees-are-hidden-from-patients-20170305-gur2kh.html>

The recent and now ongoing [series of reports on surgical variance](#) compiled by the Royal Australasian College of Surgeons (RACS) and Medibank provide a deal of information about the OOP costs involved in private surgery. These reports have not been well mined in the public arena but provide insight into the inverse relationship between quality and safety and OOP costs, especially for those surgeons who do fewer private procedures. In addition, they highlight that too much private surgery in areas like orthopedics is low-value.³

In a [Perspectives opinion piece](#) in the MJA, prominent orthopaedic surgeons also noted that there is “no correlation between the size of the fee charged and the quality of the surgery”. They called for greater transparency in specialists’ fees and suggested that Australia was lagging behind other

³ See recent papers by LR for the Pearls and Irritations blog <https://johnmenadue.com/lesley-russell-how-knee-replacement-surgery-highlights-issues-of-access-affordability-and-best-practice-in-australias-two-tiered-healthcare-system-part-1/> <https://johnmenadue.com/lesley-russell-how-knee-replacement-surgery-highlights-issues-of-access-affordability-and-best-practice-in-australias-two-tiered-healthcare-system-part-2/>

nations in developing programs for assessing the quality of outpatient care and making that information publicly available.

The impact of out-of-pocket costs for people with chronic illness

It's important to consider what the growing costs to see a specialist mean for specific groups of patients such as older Australian with multiple chronic illnesses, people under-going treatment for cancer and those needing care and treatment for mental illness, eating disorders and substance misuse.

A [recent study](#) shows 27% of older Australian reported having at least three chronic diseases, with high blood pressure, arthritis and cancer as the most prevalent diseases. [National Seniors Australia](#) found that older Australians with five or more chronic conditions spend \$3528 per year on out-of-pocket health care costs. Small wonder then that approximately 10% of adults referred to a specialist [delay or do not keep their appointment](#) because of cost. This proportion rises to over 12% in the most socioeconomically disadvantaged fifth of the population.

A diagnosis of cancer – something faced annually by some 135,000 Australians – will also incur significant OOP costs, as shown in a [recent report produced by Deloitte](#) done for the Breast Cancer Network of Australia (BCNA). These costs arise because coverage through public and private insurance schemes is not fully aligned with the clinical services required. People with cancer may also have additional costs related to paid home help, child care services, transportation and accommodation to access treatment, psychosocial support and medicines. The BCNA report found that a woman with breast cancer typically incurs a total OOP cost of \$4,809 in the first five years following diagnosis. However there was a large variation, with the middle 50% of respondents (25th to 75th percentile) reporting OOP costs of between \$1,510 and \$17,200.

A [November 2014 report](#) prepared for the Royal Australian and New Zealand College of Psychiatrists highlighted that there are a number of cost barriers preventing people with mental illnesses from receiving appropriate - or in some cases any - care. We know that people with mental illness are likely to be more financially disadvantaged, and there is [evidence of a large gap](#) in the use of mental health services between rich and poor areas, but there is surprisingly little data available about the medical OOP costs, despite the high prevalence of mental health disorders in society. A [recent review](#) is critical of the limited information on the economic impact that mental illness imposes on individuals and families particularly remarking on the lack of data on OOP costs for attention deficit hyperactivity disorder, anxiety, cognitive function, conduct disorder, eating disorders and psychological distress.

Medicare places caps on the number of psychiatry and psychology services covered and most PHI funds have [restrictions](#) in their cover for mental health services. Private hospital cover is now generally only available with the [most expensive policies](#). The limits on and affordability of psychiatric and psychological care is a [constant theme](#) in on-line forums.

APPENDIX 2

New reports and initiatives since 2015

Royal Australasian College of Surgeons and Medibank Private. Surgical Variance Reports

<https://www.surgeons.org/policies-publications/publications/surgical-variance-reports/>

Value and affordability of private health insurance and out-of-pocket medical costs. Senate Community Affairs Committee, December 2017.

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance

Ministerial Advisory Committee on Out-of-Pocket Costs established, January 2018

<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt002.htm>

Patients' out-of-pocket spending on Medicare services. Australian Institute of Health and Welfare, August 2018.

<https://www.aihw.gov.au/news-media/media-releases/2018/august/new-report-reveals-out-of-pocket-costs-for-medicar>

Patient Experiences in Australia: Summary of Findings, 2016-17. Australian Bureau of Statistics, November 2017

<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4839.0~2016-17~Main%20Features~Dental%20professionals~4>

Out-of-Pocket Pain. Consumers Health Forum of Australia, April 2018

https://chf.org.au/sites/default/files/20180404_oop_report.pdf

Needed research

Saying that more research is needed should not be used as an excuse to delay action. Rather research, evaluation, analysis and feedback should occur concurrently with implementation of initiatives.

Who bears the burden of OOP costs?

It is important that new policies target those with the largest OOP costs and those who have problems affording their health care expenses. These are not necessarily people on the lowest incomes or people with concession cards. Simply carving out exclusions on the basis of age or concessional status risks shifting costs to other vulnerable groups, thus widening inequalities and increasing preventable health problems. The first step in developing effective policies and programs to meet the needs of the most vulnerable is to find out more about them, including the following:

- What are the greatest source/s of OOP costs?
- Are all the costs incurred necessary?
- Are the difficulties in meeting health care costs genuine affordability issues or 'cash flow' problems?
- Which consumers are meeting the existing MBS/PBS safety-nets?
- What is the impact of financial imposts on these people's timely access to services, ability to receive needed treatment, compliance with recommended treatment and medication regimes?
- Do financial barriers to accessing care result in potentially preventable hospitalisations?

The business case for doctors

We need to understand more about what is important to GPs and specialists in the business sense. Too often policy changes in this area are driven by political or budgetary exigencies and ignore the day-to-day realities of general practice. It is no surprise then when these policy changes fail to deliver on the expected outcomes and/or have unintended negative consequences. Working with the profession to manage resource allocation is critical to successful outcomes in this, as in other areas of general practice. Given the diversity of medical practices it is likely that there will not be one single solution to improving the way in which we deal with OOP costs for Medicare-funded services.

Most information on doctors' views and preferences comes from the professional colleges and guilds but their position on specific issues is not necessarily representative of that of doctors at the coal face. Broader consultation with the medical profession and with others working in general practice, including practice nurses, nurse practitioners, practice managers and Aboriginal Health Workers, would assist in obtaining their views on how best to manage OOP costs. This consultation process should focus on the following questions:

- How do GPs and specialists make decisions about bulk billing and what are the factors that influence this decision?

- What do GPs and specialists like and dislike about co-payments?
- What do they see as the (realistic) alternative?
- What drives doctors to spend more / less time with a patient?
- What patients / issues do they see as time-wasting?
- What role do practice nurses, Aboriginal Health Workers and other practice staff in minimising out-of-pocket costs for primary health care?

Drivers of fee variations

The recent work of the AIHW in this area is valuable and it is important that this continues and is expanded. In particular, additional issues must include:

- The OOP costs that confront people who use mental health services.
- The impact of PBS co-payments.
- The impact of essential items (non-PBS medicines, devices, aids, wheelchairs etc) on OOP costs.
- Variations in the assistance patients and families receive with transportation, accommodation etc needs.

However additional work is needed to explore the reasons why OOP costs vary and by such large amounts. Some of this work will be addressed by the MBS Review, the recommendations of which must be made more widely available. Some specific questions to be addressed include:

- What are the factors that influence doctors billing practices and fees, especially with respect to those patients they see often because of multiple chronic conditions?
- What are / what should be the roles of the specialty medical colleges in setting fees and managing egregious instances of over-charging?