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Perspective

Co-payments for health care: what is their real cost?

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Abstract. Based on the premise that current trends in healthcare spending are unsustainable, the Australian Government has proposed in the recent Budget the introduction of a compulsory $7 co-payment to visit a General Practitioner (GP), alongside increased medication copayments. This paper is based on a recent submission to the Senate Inquiry into the impact of out-of-pocket costs in Australia. It is based on a growing body of evidence highlighting the substantial economic burden faced by individuals and families as a result of out-of-pocket costs for health care and their flow-on effects on healthcare access, outcomes and long-term healthcare costs. It is argued that a compulsory minimum co-payment for GP consultations will exacerbate these burdens and significantly undermine the tenets of universal access in Medicare. Alternative recommendations are provided that may help harness unsustainable health spending while promoting an equitable and fair health system.

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Introduction

Constraining the growth of spending on health is important for Australia's future economic viability, particularly if the benefits of such spending do not justify the costs. However, the recent proposal by the Australian Government to introduce a compulsory $7 payment when visiting General Practitioners (GP) and for ordering tests alongside increased Pharmaceutical Benefits Scheme (PBS) co-payments, are unlikely to be effective in the long-term and will undermine the tenet of universal access.

Based on a recent submission to the Senate Inquiry into the impact of out-of-pocket costs in Australia,[1] this paper provides an overview of current trends in health-related out-of-pocket expenditure in Australia and the expected impact of increased co-payments on individuals and the health system. We examine the proposals in relation to the main drivers of cost in the Australian healthcare system and provide alternative recommendations that will preserve the essential elements of universalism while maintaining a financially sustainable health system.

What out-of-pocket expenditures do Australian health consumers face?

Out-of-pocket expenses (excluding the cost of private health insurance premiums) comprise approximately 18% of health spending in Australia. This is higher than the Organisation for Economic Co-operation and Development (OECD) median of 15.8%.[2] Across 14 OECD countries, only residents of Switzerland and the USA pay more out-of-pocket for their health care.[3]

In 2009, the annual mean out-of-pocket household expenditure on health care was $3585 and $3377 for older and younger households respectively.[4] As a proportion of their total household budget, older households incurred much higher out-of-pocket expenditure (9.4%) than younger households (4.7%).[4] For older households, the cost of medicines (mainly non-prescription and to a lesser extent, PBS prescriptions co-payments) was the biggest out-of-pocket expenditure item. For younger households, substantially more was spent on health practitioners' fees and less was spent on medicines, but private health insurance was the biggest expense.[4]

For people with chronic disease, the burden of out-of-pocket costs is particularly pronounced. Patients face co-payments at various places in the system: GP and specialist appointments, diagnostic tests and medications. Patients with chronic obstructive pulmonary disease and chronic kidney disease have out-of-pocket expenses of $600–$1400 per quarter on medical services, medications, community services and transport.[5,6] While safety net programs exist to limit personal spending on Medicare-eligible out-of-hospital care and PBS-listed medicines, patients often cannot pay the out-of-pocket costs needed to reach the set thresholds each year. Additionally, some expenses (e.g. medical devices, over-the-counter medications, non-PBS-listed medicines) do not qualify for the safety net programs, swelling the burden of out-of-pocket payments.

Growing evidence shows that out-of-pocket costs comprise much of the household economic burden of many chronic and long-term illnesses.[5–9] Each additional chronic disease adds 46% to the likelihood that a person faces severe financial difficulties, often compounding existing levels of financial stress.[10,11]

What is the impact of increasing co-payments on healthcare access and outcomes?

In 2005, PBS co-payments were raised by over 20%. Following this, fulfillment of prescriptions for medicines to prevent or treat cardiovascular disease, epilepsy, glaucoma, Parkinson's disease, asthma, osteoporosis and thyroid deficiency significantly declined.[12] The decrease in dispensing of such essential medicines was greater for social security beneficiaries than for general PBS beneficiaries.[12,13] International research has confirmed this pattern of reduced uptake of prescribed medications by publicly ensured consumers facing rising prescription co-payments.[14,15]

The consequences of not obtaining prescribed medications can be serious. Patients with hypertension who are non-adherent almost double their likelihood of hospitalisation.[16] Of a cohort of GPs surveyed in Western Sydney, most thought that at least some of their patients had experienced deterioration in health, hospitalisation or death as a consequence of cost-related non-adherence.[17] Anecdotal evidence from many GP colleagues report patients who halve their prescribed dose by either splitting their tablets or taking them on alternate days, to ease the cost burden of their prescriptions.

In addition to medications, out-of-pocket costs have a direct impact on access to health care. In Australia, up to 14% of adults reported not attending the doctor or not getting recommended care because of cost.[18,19] Among those living with chronic health problems, this proportion was 24%.[19] Again, these findings are consistent with international evidence.[20,21]

Gap payments and PBS co-payments impact most significantly on the poor – those who are most likely to suffer ill health in the first place.[5–8,22] The empirical evidence evaluating the effect of co-payment on healthcare demand clearly identifies that individuals with lower incomes reduce their use of healthcare services to a greater extent in response to increased co-payments.[20,21]

Limited empirical evidence exists to analyse the long-term health effects of co-payments for health care,[20] although there is some indication that reduced access and utilisation of otherwise cost-effective health care result from higher co-payments, particularly among those with chronic illnesses.[21]

Are co-payments the right 'price signal' to deter unnecessary healthcare use?

Some have argued that a 'price signal' will deter unnecessary healthcare use. While a higher patient charge creates a new cost barrier and may deter utilisation,[20] we cannot presume that consumers know the severity and prognosis of a condition before a consultation and can discriminate between necessary and unnecessary services. Indeed, patients visit a GP because they require information about the health care they need. Every GP consultation is an opportunity for detecting asymptomatic disease, reducing risk, addressing unhealthy behaviour and promoting health.[23] A co-payment would reduce these opportunities with potential long-term impacts on both health and healthcare costs.[24]

By contrast, reducing cost barriers to health care and medications can improve access and use of essential medications.[25] The national Closing the Gap (CTG) initiative includes two measures that directly reduce cost barriers to healthcare access for Indigenous Australians: prescription co-payments for enrolled Aboriginal or Torres Strait Islander patients who have, or are at risk of, a chronic disease; and gap payments between specialist fees and the Medicare rebate. Prescribers accessing such schemes for their patients anecdotally report a marked increase in adherence to essential medications and access to specialist care. Although evidence of its impact on outcomes is not yet available, the CTG scheme represents an important initiative in addressing Aboriginal health disadvantage through the removal of financial barriers to care.

What current strategies exist to protect Australian consumers from high healthcare costs?

Private health insurance

Private health insurance in Australia is highly subsidised by public funds: directly through the private health insurance

rebate and indirectly through Medicare Benefits Schedule and PBS subsidies. Publically funded hospitals pay for most acute medical care, irrespective of private health insurance status.

Solutions to the cost burden of out-of-pocket expenses cannot come from higher levels of private health insurance coverage. A recent study found that households with private health insurance spent approximately fourfold more on health care than those without such cover. The cost of the insurance premiums accounted for approximately half of this difference.[4]

There is a real risk that current proposals to allow private health insurance to cover more of the gap in healthcare costs will have a moral hazard effect – enabling increases in medical fees while cushioning the insured from their impact. Those without private insurance would face the full impact of increasing fees. In turn, this could have flow-on effects for Commonwealth expenditure; the increased out-of-pocket expenses will result in more people exceeding the safety net threshold. It is also likely to place upwards pressure on private health insurance premiums which, through the private health insurance rebate, will have consequences for Commonwealth health expenditure.

Safety nets and other offsets

Approximately 80% of general practice consultations are bulk billed. Yet of specialists' appointments for clinic care, this figure is less than 30%.[26] Although gap payments (i.e. the difference between the private fee charged by a specialist and the Medicare benefit received by a patient) are, on average, approximately $60, gaps in excess of $100 or more are not uncommonly incurred.

Most private specialists do not bulk bill. With gap fees being unaffordable for the poor in the first place, less than 4% of Extended Medicare Safety Net benefits are distributed to 20% of the most socioeconomically disadvantaged members of our population. By comparison, more than half of the benefits are distributed to the 20% most advantaged.[27] Some of these may present for treatment later as public hospital outpatients but this is nevertheless a failure in policy – those least likely to benefit from the Extended Medicare Safety Net are the poor who have the lowest discretionary income and are most likely to experience ill-health.

Nine per cent of adults delay or fail to fill prescriptions because of cost; this rises to more than 12% in the most socioeconomically disadvantaged fifth of the population.[18] Despite concession card holders incurring a reduced lower prescription co-payment, many patients with chronic illness who are economically disadvantaged cannot afford the co-payments on earlier prescriptions and will not reach the PBS safety net. Furthermore, the Medicare and PBS safety net programs are not easy to use, with patients reporting problems understanding safety net requirements and being unaware of their eligibility.[7,22] Other challenges cited include: program timing (the need to re-qualify each calendar year); complex administrative requirements (inconsistent processes, a need to record personal spending, eligibility differences for families compared with individuals); and program inequities (couples qualify before singles in elderly households).

Although simplification of the present safety net system proposed by the Australian Government in the 2014 Budget may make the safety net system more accessible, the concomitant reduction in the maximum amount of out-of-pocket costs that will be reimbursed through Medicare and the increased limits on the type of expenses that count towards the safety net do nothing to protect those most vulnerable from the economic burden that occurs as a result of high out-of-pocket healthcare costs.

Bulk billing incentives

Unlike GPs, specialists do not receive incentive payments for bulk billing consultations. A Medicare incentive for specialists to bulk bill consultations and other services for concession card holders and children, which is what GPs currently receive, would help to address the financial barrier faced by many patients. Furthermore, as relatively few specialists work outside metropolitan regions nor within less affluent metropolitan areas,[27] this type of incentive could redress the potential revenue difference for specialist practices between affluent and deprived communities. A bulk billing incentive would be more socially fair than the Extended Medicare Safety Net.[28]

Conclusions

A compulsory co-payment for bulk billed GP consultations will exacerbate already high financial barriers that Australians face when accessing health care and essential medications, and further undermine any claims that our current health system has to equity and fairness.

The key to a financially sustainable healthcare system is a primary healthcare system that is accessible to all and which enables individuals to obtain early diagnosis and treatment, thus averting higher downstream healthcare costs that inevitably arise through delayed access to care. Instead of creating a barrier to access primary health care through the introduction of compulsory co-payments, the Federal Government should do more to curb unsustainable spending by addressing current inadequacies within the health system.

Given the burden of out-of-pocket costs found in the general population, and in people with chronic disease in particular, there is an urgent need to review the impact of out-of-pocket expenditure in the current system. We therefore endorse the recommendation made by the Consumer's Health Forum to improve the current system by developing a national policy on co-payments, informed by community consultation and the growing body of Australian research.[22] Our concern with the recent Budget announcement is the serious erosion to the principle of universalism that has underpinned Medicare for the past three decades.

Competing interests

TU is a General Practitioner.

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