

TACKLING OUT-OF-POCKET HEALTH CARE COSTS

A Discussion Paper

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About this paper

The issue of growing out-of-pocket (OOP) costs and their impact on the ability of Australians to access needed health care is undermining the universality of Medicare, widening health inequalities and arguably leading to increased hospital costs.

Currently, individual co-payments comprise around 17% of total health care expenditure in Australia – the largest non-government source of funding for health goods and services.¹ This includes where individuals meet the full cost of goods and services -for example, medications that are not subsidised by the PBS, health services not subject to a Medicare rebate - and where individuals share the cost of health goods and services with third party payers such as Medicare and private health insurance funds.

This contribution by individuals represents a higher proportion of health care funding than in most other OECD countries and equates to \$1,078 per capita. Moreover, in most OECD countries over the last decade the proportion of total expenditure coming from individual co-payments has been decreasing, while in Australia out-of-pocket expenditure on health per capita continues to grow at a faster rate than the broader economy, average incomes and overall household expenditure.²

Measured in current prices, out-of pocket expenditure on health per capita has grown by 89.0% over the decade to 2011–12. In particular, total patient out-of-pocket expenses for primary and specialist care have significantly increased over the past 10 years, rising from \$9.7 billion in 2001–02 to \$17.1 billion in 2011–12, a 76% increase.³ The average cost of a GP visit in 2013-14 was \$47 from Medicare plus \$5 from the patient. For a private specialist, the average visit cost \$82 from Medicare plus \$38 from the patient.⁴

About one-third of individuals' out-of-pocket costs go for medicines, and although this includes nutritional supplements and 'complementary' and 'alternative' medicines, the out-of-pocket costs of essential over-the-counter and prescription medicines is also rising.⁵

While these figures give a general guide to medical OOP costs, it is important to understand that in health care there are few 'average' patients. That is because health care usage (and health care costs) are not evenly distributed across the population. Increasing numbers of Australians are incurring high

¹ Senate Reference Committee on Community Affairs. Out-of-pocket costs in Australian healthcare. August 2014. [http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~media/committees/clac_ctte/australian_healthcare/report.pdf](http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~/media/committees/clac_ctte/australian_healthcare/report.pdf)

² Ibid

³ Ibid

⁴ Britt H. General practice and value for money. John Menadue website 15 December 2014. <http://johnmenadue.com/blog/?p=2922>

⁵ Senate Reference Committee on Community Affairs. Out-of-pocket costs in Australian healthcare. August 2014. http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~media/committees/clac_ctte/australian_healthcare/report.pdf

OOP costs on a regular basis, due to factors such as their location, type of illness and the availability of public health care services.

People with chronic illnesses and disabilities use health care much more often than the rest of the population and the increase in out-of-pocket costs falls disproportionately on this group, which already has a lower average income, thus compounding their financial disadvantage. So begins a vicious cycle, where those with poor health and fewer financial resources must pay proportionately more out-of-pocket for their needed care, meaning they often go without.

The Abbott Government has pushed to introduce or increase co-payments, claiming variously that growth in health care costs is unsustainable, price signals are needed to reduce GP visits, budget deficits must be addressed and increased funding is needed for medical research. But targeting primary care for cost savings will quickly backfire. Research shows that while the number of GP visits has increased, these services are cost-effective; if the same services were performed in other areas of the health care system, they would cost considerably more.⁶

The World Health Organisation has highlighted some of the potential negative consequences of co-payments, including the fact that they are the least equitable form of health funding because they are regressive (the rich pay the same amount as the poor for any particular service).⁷ There is now a raft of Australian reports highlighting the adverse impacts of co-payments.⁸

It is clear that whether the policy focus is on economic, health or social equity outcomes, greater attention needs to be paid to tackling rising out-of-pocket costs. With our ageing population and rising rates of chronic conditions, we can expect that there will be increasing numbers of Australians requiring long-term health and medical care from a range of different providers and in both hospital and community settings. Our current health care financing systems and safety-net arrangements are inadequate in meeting the needs of this group to ensure they can manage their health care costs and afford the services they need.

This is a difficult topic – it involves a potent mix of evidence, ideology, consultation and leadership. There is no silver bullet and effective solutions are unlikely to be found through simple ‘add ons’ to our current health funding system, developed in an age where the majority of health care was for short-term, acute problems. They are more likely to involve a multi-faceted approach and require a re-thinking of the ways in which we generate and allocate our health care resources and ensure health care funding decisions reflect our society’s underlying values.

⁶ Britt H, Miller GC, Henderson J, et al. A decade of Australian general practice activity 2004–05 to 2013–14. General practice series no. 37. Sydney: Sydney University Press, 2014

http://ses.library.usyd.edu.au/bitstream/2123/11883/4/9781743324240_ONLINE.pdf

⁷ WHO (2003). Drugs and Money: Prices, Affordability and Cost Containment.

<http://apps.who.int/medicinedocs/en/d/Js4912e/3.4.html>

⁸ The most recent of these are summarised at Russell L. Analysis of 2014-15 Health Budget: Unfair and unhealthy.

<http://ses.library.usyd.edu.au/bitstream/2123/11981/1/2014-15healthbudget.pdf>

To kick-start the necessary analyses, debates and policy formulations, we have developed this discussion paper which lays out some of the issues, as we see them. It is admittedly short on solutions, but we are hopeful these will come. There is no shortage of collated evidence and expert advice available drive policy development – all that is needed is leadership.

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General approach

The focus of this paper is on out-of-pocket (OOP) costs that arise from community-based care provided under Medicare by health care practitioners (GPs, specialists and allied health services). While there are a range of other costs incurred by consumers when accessing health care, OOPs associated with Medicare-subsidised services are an important component of total health care costs for most consumers and reducing these, where they are a barrier to access, will increase overall access to care.

Approaches that involve simply increasing the Medicare rebate and widening the current safety nets have been excluded as these would be unlikely to achieve the desired policy outcome and in any case would not be politically palatable.

The approach taken is informed by the substantial evidence supporting the benefits of increasing access to primary care. There is convincing data from a range of sources that timely and affordable access to prevention and primary care services is key to improved health outcomes and sustainable health care costs.⁹ Indeed, we should not shy away from spending more on primary care if this is spent effectively and includes those who are currently under-served. We know that many Australians currently go without needed preventive and primary care services, especially those in rural and remote areas, people with mental illness and Indigenous Australians. Increasing access to primary health care for these groups can improve overall health outcomes, reduce the need for hospitalisation and increase the efficiency of resource allocation.

It is important that any proposed changes are assessed against the following criteria:

- Evidence-based;
- Led by community values and priorities;
- Do not increase inequality;
- Do not reduce quality of care;
- Recognise the business case for providers and take into account their preferred ways of working and professional cultures;
- Are realistic within current legislative, workforce and political constraints;
- Do not create unexpected consequences and inefficiencies elsewhere within the healthcare system;
- Target those who most need assistance; and
- Do not undermine the sustainability of the health care system.

It will be important that the aims of any new proposals are clearly articulated and evaluated against these criteria.

⁹ Department of Health and Ageing. Improving Primary Health Care for All Australians. 2011. <http://webarchive.nla.gov.au/gov/20140801024641/http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/featurednews-20110222a>

Preliminary research needed

Some basic research is needed to provide the foundations and evidence for policy changes to address OOP costs in an effective and targeted fashion and to avoid predictable unintended consequences.

What does the public want?

There has been little or no attempt to engage the Australian people in the current political debate over health care costs. Taking the time and effort to consult with all the stakeholders, especially taxpayers, and obtain their feedback on new proposals is key to community buy-in, or at least understanding and acceptance of, changes in iconic federal programs like Medicare.

We do not have a good sense of whether Australians think national spending on health care is at the right level and what they think is the appropriate mix of tax-funded / individual-funded contributions. There is some evidence of support for increasing the Medicare levy,¹⁰ although this has never been widely tested.

In 2007, when Australia undertook a wide-ranging review of the health system via the National Health and Hospitals Reform Commission, there was no systematic process to gather community views. This differed from the approach taken by Canada which undertook a similar review and included a number of different processes to consult with consumers and the broader community on key health funding issues.¹¹ Without such a consultative process Australian governments and policy makers are operating in a vacuum, developing policies based on unsubstantiated assumptions about community views.

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?

¹⁰ Why we'll happily pay the Medicare Levy (just don't call it a tax). Crikey 1 May 2013. http://www.crikey.com.au/2013/05/01/why-well-happily-pay-the-medicare-levy-just-dont-call-it-a-tax/?wpmw_switcher=mobile

¹¹ Citizens' Dialogue on the Future of Health Care in Canada. Website <http://participedia.net/en/cases/citizens-dialogue-future-health-care-canada>

- 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:

- 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?

Areas for consideration for policy development

Registration with general practice

Patient enrolment formalises a relationship between a health care professional / health care practice and the patient. The formal patient links with an identifiable source of care are variously known as registration, enrolment, rostering or personal lists.

This formalisation of a commitment by both patient and service provider about the provision of primary care services is potentially beneficial for both.¹² For the patient, it can provide a clearer or firmer guarantee of continued care from a single, known source and help with referrals to other health services as required. This in turn is likely to lead to better health outcomes, all other things being equal, due to improved continuity of care. For the service provider, enrolment can give greater certainty in some aspects of clinical practice, given the provider's relationship with and knowledge of the patient's history and current health issues.¹³ While patient enrolment is not sufficient to ensure coordination and continuity of care, it is seen in many quarters as a critical foundation for good primary care.

We recommend exploring the value of having people most at risk of high OOP costs register with a GP / general practice of their choice to help with coordinated care and follow-up. Registration could be extended to pharmacists / pharmacies to ensure appropriate use of medicines.

This approach could 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.
- There will potentially be a decrease in duplicate tests and better continuity and coordination of care.
- GPs will know the disease burden of their patients and this provides the opportunity to restructure Medicare payments to take account of this, for example, by providing for longer consultations.

If patient enrolment resulted in savings through, for example, reduced testing and hospitalisation, these would off-set the costs of subsidising OOP costs for this group of patients.

Better utilisation of the health workforce

There is growing recognition of the need to reorient the primary care system towards multidisciplinary care teams and not rely solely on GPs as the providers of care. To date the rhetoric has not been matched by the practice.

¹² Kalucy L, Katterl R, Jackson-Bowers E & Hordacre A-L. Models of Patient Enrolment. PHCRIS 2009. http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/news_8363.pdf

¹³ Manious AG, Baker R, Love M et al. Continuity of care and trust in one's physician: evidence from primary care in the US and UK. Family Medicine 2001; 33: 22-27. <http://www.stfm.org/Fullpdf/Jan01/special.pdf>

There are currently 11,000 nurses in general practices in Australia but they are very under-utilised. There are many areas where nurses can provide needed care cost-effectively and in ways that can free busy doctors for those patients who need their specific skills.¹⁴ Similar arguments can be made for allied health professionals, community and Aboriginal health workers, midwives and nurse practitioners. There's also a case for including pharmacists and dental professionals on this list.

Too often in Australia suggestions about expanding scopes of practice degenerate into arguments about professional turf which ignore training, skills and best use of resources. We acknowledge that issues around scope of practice are inextricably linked to patient safety and note that they are necessary in the pursuance of good clinical governance. On the other hand, making optimal use of the full primary care workforce can ensure timely access to high quality and culturally sensitive care. The real challenge is to structure the reimbursement mechanisms to reward skills and training, ensure the appropriate degree of professional independence, encourage teamwork and limit costs to individuals. To date there has been no real willingness to tackle these issues which offer some real potential to reduce OOP costs and health inequalities.

There is also a need to look at the relationship between workforce density and OOP costs. There are some clear patterns of high levels of bulk billing corresponding to areas of high doctor density. This brings up the question of whether a more equitable workforce distribution might help ensure a more equitable distribution of OOP costs across the population.

Reconsidering the GP gatekeeper role

The role of the GP as gatekeeper / coordinator of services is one of the keys of success of the Australian health care system. We do not advocate changing this in any substantial way; what we do advocate is a fresh look at this role to see where it is necessary and where it is anachronistic. Money is not necessarily wasted when a patient sees a GP for the renewal of a long-standing prescription or for a referral to a specialist for diagnostic imaging. But does this need to happen all the time for every patient? Is there scope in some areas and for some patients for other health professionals, such as practice nurses or pharmacists, to provide some gatekeeper/coordination services (see the section above)?

We believe that the GP gatekeeper role should be scrutinised to determine if there are some areas where it is unnecessary and increases costs for both patients and Medicare. Current concerns about co-payments have focused on reducing patient- driven GP visits, but the need for repeat or other prescriptions and renewal of specialist referrals creates opportunistic GP contact. Reducing this 'enforced' contact carries a risk and managing this risk requires assessment of the need to alter scopes of practice and improve coordination of care.¹⁵

¹⁴ See for example Harris M & Lloyd J. The role of Australian primary health care in the prevention of chronic disease. Review commissioned by the Australian National Preventive Health Agency. September 2012. [http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/28433043152D3FD5CA257B7E00270FED/\\$File/M%20Harris%20paper%202012%20-%20final.pdf](http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/28433043152D3FD5CA257B7E00270FED/$File/M%20Harris%20paper%202012%20-%20final.pdf)

¹⁵ Nydam K. Gatekeeper, shopkeeper, scientist, coach? Australian Family Physician 2012 41(7): 457. <http://www.racgp.org.au/afp/2012/july/gatekeeper,-shopkeeper,-scientist,-coach/>

Tackling over-testing and over-prescribing

Almost every doctor visit generates additional costs from prescriptions, diagnostic tests and investigations. Over the past decade there has been a significant increase in the proportion of problems for which pathology and / or imaging was ordered.¹⁶ Some of this is a consequence of new technologies, and some is due to better management of chronic conditions. But some is over-utilisation. For example a 2007 study by the Commonwealth Fund found that 15% of Australians reported undergoing repeat imaging.¹⁷ The escalated use of diagnostic imaging has also been associated with the potential for 'treatment cascades' that subsequently lead to procedures that may be of low value to patients or even unnecessary.¹⁸

Australia has done little in terms of quality and quantity control of tests ordered and understanding prescribing patterns by GPs and specialists. There is much more that can and should be done in terms of external quality reviews and peer reviews to identify where doctors are ordering tests and prescribing inappropriately or unnecessarily. A more contentious possibility is that Medicare develops set packages of tests, with some flexibility for implementation, for certain common conditions (eg back pain, chest pain) and reimburses only for this package. This approach could certainly constrain Medicare costs; it would need patient education to ensure OOP costs did not grow as a consequence.

An initial step would be to work with the medical profession and consumers to identify areas in which over-testing and / or prescribing is common and to develop standardised packages of tests and medication regimes which support quality clinical practices in these areas.

Establishment of community health centres with salaried staff

In the interests of pragmatism we are not proposing the abolishment of fee-for-service (FFS) which is the basis of the majority of Medicare payments to doctors, and coincidentally, the reason for increasing OOP costs. However we do conclude that 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.¹⁹ 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

¹⁶ Britt H, Miller GC, Henderson J, et al. A decade of Australian general practice activity 2004–05 to 2013–14. General practice series no. 37. Sydney: Sydney University Press, 2014
http://ses.library.usyd.edu.au/bitstream/2123/11883/4/9781743324240_ONLINE.pdf

¹⁷ Commonwealth Fund International Health Policy Survey of Sicker Adults. 2008.
<http://www.commonwealthfund.org/Content/Surveys/2008/2008-Commonwealth-Fund-International-Health-Policy-Survey-of-Sicker-Adults.aspx>

¹⁸ Canadian Agency for Drugs and Technology in Health. Appropriate utilization of advanced diagnostic imaging procedures: CT, MRI, and PET/CT. Environmental scan. February 2013.
http://www.cadth.ca/media/pdf/PFDIESLiteratureScan_e_es.pdf

¹⁹ Hing E and Hooker RS. Community Health Centers: Providers, Patients and Content of Care. NCHS Data Brief No 65, July 2011. <http://www.cdc.gov/nchs/data/databriefs/db65.htm>

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 copayments 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.

Increasing the value of existing health expenditure

As there are always limits on our health budget, it is essential that we ensure that all health funding is allocated to achieve maximum benefit. Improving the value we obtain from our existing expenditure on health care will help take pressure off our health budgets and reduce the need to increase consumer co-payments. Before consumers are asked to increase their direct contribution to health care, all reasonable measures should be implemented to increase the benefits obtained from existing health funding sources. The following examples provide practical suggestions for achieving this aim.

Identification of low-value health care procedures

While some work has commenced on reviewing MBS items²⁰ and identifying low-value health care practices²¹, a concerted effort is required in this space, together with education and incentives to encourage disinvestment in these. This will not necessarily address OOP costs but will ensure better value for spend.

By taking an approach like the Choosing Wisely program²² this work can be undertaken by the medical professions at the coal face, rather than bureaucrats in Canberra. The involvement of consumers and patients during the decision-making process and in individual discussion with their clinicians also provides an opportunity for them to understand the value and the cost of their treatment.

Increased professional development activities focused on identifying and reducing low-value procedures and peer review processes which support doctors to make better treatment recommendations would assist in reducing the numbers of low-value practices funded by Medicare.

²⁰ Department of Health. MBS reviews.

<http://www.msac.gov.au/internet/msac/publishing.nsf/Content/reviews-lp>

²¹ Elshaug AG, Watt AM, Mundy L, Willis CD. Over 150 potentially low-value health care practices: an Australian study. *Med J Aust* 2012; 197(10):556-560. <https://www.mja.com.au/journal/2012/197/10/over-150-potentially-low-value-health-care-practices-australian-study>

²² ABIM Foundation. Choosing Wisely. <http://www.choosingwisely.org/>

The main outcome of this approach is around quality care and sustainable costs, but there will also be financial benefits that accrue to patients.

Improving Clinical practices

Low value services are linked to over-testing and over-prescribing (see above) and also to unwarranted variation in health care services. While some work has begun around exploring and understanding health care service variation,²³ Australia has been slow to address this important area.

There is evidence of significant medical practice variation in Australia, indicating that current practices do not represent the best value for our health dollars. For example, the Australian Council on Safety and Quality in Health Care has found a sevenfold variation in cardiac catheterization between the highest and lowest intervention Medicare Local area.²⁴ There is also some evidence indicating that over-servicing and over-testing occurs in some areas of our health system, for example, testing for Vitamin D levels²⁵. Strategies to reduce these practices should be developed and implemented, in conjunction with the medical profession and consumers, in order to ensure the best value is obtained for the health care dollars spent by both patients and governments.

Increased generic substitution

A 2013 paper from the Grattan Institute highlights that the Australian Government could save at least \$550 million every year by encouraging doctors, pharmacists and patients to increase the uptake of generic drugs and bargaining harder on the price paid for generics.²⁶

The average annual increase in OOP costs for prescription pharmaceuticals over the last 14 years has been 2.1%, compared with 2.8% for the entire CPI.²⁷ However for many people with multiple prescriptions the costs of their medicines are prohibitive, leading to scripts not filled and doses skipped.

²³ Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare. Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study. Sydney: ACSQHC, 2014. <http://www.safetyandquality.gov.au/wp-content/uploads/2014/05/Exploring-Healthcare-Variation-in-Australia-Analyses-Resulting-from-an-OECD-Study.pdf>

²⁴ Australian Council on Safety and Quality in Health Care (ACSQHC) Medical Practice Variation: Background Paper Sydney: ACSQHC, 2013. http://www.safetyandquality.gov.au/wp-content/uploads/2013/10/SAQ110_Medical_Practice_variation_V10_WEB.pdf

²⁵ Morgan S and Coleman J We live in testing times: Teaching rational test ordering in general practice. Aust Fam Physician 2014; 43 (5): 273-276. <http://www.ncbi.nlm.nih.gov/pubmed/24791766>

²⁶ Duckett S. Australia's bad drug deal. High pharmaceutical prices. Grattan Institute. March 2013. http://grattan.edu.au/wp-content/uploads/2014/04/Australias_Bad_Drug_Deal_FINAL.pdf

²⁷ Pharmacy Guild of Australia. Submission to Senate Standing Committees on Community Affairs Inquiry: Out-of-pocket costs in Australian healthcare. May 2014. [http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~media/committees/clac_ctte/australian_healthcare/report.pdf](http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~/media/committees/clac_ctte/australian_healthcare/report.pdf)

The case can be made that for certain people who need a substantial number of regular medications, PBS co-payments should be reduced further to ensure affordable access and compliance with medication regimes. In such cases simply providing a safety net does not assist people who are high users of medicines and on a low income as they are unable to meet the costs necessary to reach the safety net threshold.

Transparency around specialist fees

In recent years Government action has been taken to address blow-outs in the costs of the Extended Medicare Safety Net attributed to exorbitantly high fees being charged by some specialists.²⁸

Some evidence can be gleaned from Medicare data that there has been a substantial increase in Medicare reimbursements for specialists in recent years, particularly to cardiologists, ophthalmologists, gastroenterologists and anaesthetists. Anecdotal evidence indicates that there is a wide range of fees charged, with some specialists charging dramatically more than the AMA recommended fee (which is itself higher than the MBS reimbursement). However there is no evidence that specialists charging the highest fees deliver the best outcomes.

We therefore would like to see greater transparency around specialists' outpatient fees and the OOP costs to the patient. Patients and referring GPs might make different choices about specialist care if they knew the costs involved. At the very least the major outliers should be named and shamed. It is also important that consumers are provided with comprehensive information about their health care choices and are made aware of options, such as public outpatient clinics, where they can receive specialist services at no (or lower) cost.

Consumer payment strategies

Problems associated with OOP costs for Medicare-funded services for consumers are a function of a range of different factors, including the following:

- Their disposable income;
- Their total health care costs;
- The duration of their illness/disability;
- The predictability of their illness/disability;
- The impact of their illness/disability on their employment;
- The non-health care costs associated with their illness/disability; and
- Their level of savings/emergency funds.

Where OOP costs are considered reasonable, there may be a role for supporting consumers to afford their medical expenses through strategies which target the timing of payments. For example, unexpected health care expenses can create a barrier to accessing care for people who may not have a

²⁸ CHERE. Extended Medicare Safety Net. Review of capping arrangements. Report 2011. [http://www.health.gov.au/internet/main/publishing.nsf/Content/2011_Review_Extended_Medicare_Safety_Net/\\$File/Final%20Report%20-%20Review%20of%20EMSN%20benefit%20capping%20June%202011.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/2011_Review_Extended_Medicare_Safety_Net/$File/Final%20Report%20-%20Review%20of%20EMSN%20benefit%20capping%20June%202011.pdf)

problem meeting these costs over the longer term. There may be a role for the Government to provide low or no interest loans to people to assist them in meeting high, short-term health care costs.

Conclusion

Many of the issues we have laid out for consideration highlight the growing need to focus on delivering value and quality in health care. The US health care system demonstrates in many ways that the most expensive care is not necessarily the best care, so it is in the best interests of all the funders of health care – governments, private health insurers and especially patients – to determine that their money is spent as wisely and as well as possible.

At the same time it is necessary to ensure that those with the greatest health care needs are protected from the cost barriers that limit their access to needed services. Failure to do this has consequences well beyond the individual, with increased acute care and disability costs and reduced productivity.

In part because overall Australian health outcomes - as indicated by broad measures like life expectancy and infant mortality - are so good we have allowed ourselves to be blinded to the increasing erosion of the universality of Medicare and the subsequent widening in health disparities. Under a truly universal health care system we all pay in according to our means and take out according to our needs. We never know when or if the time will come for even the wealthiest of us to receive health care costing well beyond any expectations.

We are well aware that these proposals for addressing OOP costs will be seen as controversial, even outrageous, by some. Our purpose is to galvanise thought, evidence and action to address this key issue of fairness and equity.

We look forward to your comments and your own proposals.