Senate Committee Submission by John Menadue

Out of pocket costs in Australian Healthcare

Health Co-payments – a dog's breakfast!

There has been a lot of superficial comment following the suggestion of a proposed $6 co-payment for GP visits.

What we should be addressing is first, the chaotic nature of our co-payments and second, whether individuals and families should be making a greater direct contribution to their health expenses. The last Nielson Poll suggests that Australians are open to making a greater direct contribution.

We already have a high level of co-payments in Australia. This has been pointed out repeatedly by Jennifer Doggett. In this submission I draw on the background which she has presented over several years .

In Australia co-payments contribute over $A24 billion p.a. to our health sector. These co-payments are the third highest as a source of health funding – after Federal and State funding.

This amount of $24 billion p.a. or 17% of our total health funding is high by world standards. Australians pay a higher proportion of their healthcare costs through co-payments than citizens of most other OECD countries. The Commonwealth Fund has found that when healthcare spending is adjusted for the cost of living in Australia, we pay more in direct co-payments than all other counties surveyed apart from Switzerland and the US. Our annual health co-payments per capital are about $US750 compared with Germany $US600, New Zealand $US330 and the UK $US 310.

The problem with our co-payments is not that they are low. It is that this whole area of co-payments lacks any rhyme or reason. It is a dog's breakfast.

Consider how the percentage of total funding from consumer co-payments varies.

- Public hospitals 2.5%
- Private hospitals 11%
- Medical services 12%
- PBS medicines 16%
- Dental services 56%
- Aids and appliances 69%
- Non-PBS medicines 92%

In an unpublished paper Jennifer Doggett has pointed out that there is a wide variation in the impact of co-payments on people with different illnesses and disabilities. She says for example that people with conditions that can be largely treated by GPs or within the public hospital system, generally incur lower co-payments than those with conditions that require allied healthcare and over-the-counter medicines. This is the case independently of the length or severity of the illness/disability and its impact on both individuals and society. In fact, people with ongoing chronic conditions often end up receiving lower levels of subsidy for their healthcare than those with one-off or self-limiting conditions. Another result of this ad hoc and uncoordinated approach to co-payments

is that some people receive almost all their healthcare free at the point of service, and others, with conditions which may be more serious or longer term, face crippling costs for their treatment. For example, someone receiving emergency surgery for, say, the removal of an appendix in a public hospital, can incur no out-of-pocket costs for their treatment, whereas someone with a long-term genetic condition such as Cystic Fibrosis can incur high ongoing costs. The result is a very inequitable allocation of healthcare resources which has a particularly negative impact on people with chronic conditions.

The National Centre for Social and Economic Modelling has found that 'more and more families are finding it difficult to stretch the family budget to meet the costs of healthcare'.

This chaotic mess in co-payments is not surprising. Ian McAuley and I referred to this problem many years ago. In a paper by the Centre for Policy Development in 2007 we said 'These co-payments have been introduced without any coherence and therefore inequities and perverse incentives abound. Some services such as public hospital services are free. Some such as pharmaceutical benefits are capped by the government. Some, such as the co-payment for medical services below the safety net thresholds are open-ended; the public subsidy is fixed, leaving the user to bear an open-ended risk. Some such as the medical safety net provisions are proportional to the price of the service. Some safety nets are set on a family basis, others on an individual basis. Some are on a calendar year basis and others on a financial year basis.

In light of the chaotic nature of co-payments we need to restructure our co-payments. How should these co-payments be restructured? Several years ago at CPD, Ian McAuley and I set out some criteria which should be adopted in the design of future co-payments. We suggested

- That co-payments be controlled by the government rather than left open-ended to be set by service providers.
- That there be only one channel of collecting co-payments, with one set of criteria rather than the separate channels operating at present.
- That the level of co-payments relate to means, including people's access to liquidity.
- That means-tested compensation be separated from service delivery, rather than having service providers check the income or welfare status of users.
- That co-payments be structured in a way not to distort resource allocation on the basis of needs.
- That gap insurance, which is designed to evade co-payments, be prohibited.

In summary,

1. We already have high levels of co-payments.
2. These co-payments lack rhyme or reason.
3. Most Australians have much higher incomes than when Medicare was introduced. Subject to means-testing we should contribute more to our health costs. Co-payments, if well-structured, can help people make better choices with what economists call "price signals" They can provide also some relief to public budgets. A universal health service like Medicare does not have to be free. But it must be a high quality service available to all regardless of means.

The $6 suggestion on co-payments for visits to GPs must be considered in a much wider context. On its own it is a silly suggestion.