

# **CUTTING HEALTH COSTS: LOWERING OUT-OF-POCKET EXPENSES BY CHANGING PROCESSES**

**David Baker**

Australia has had a system of state funded universal health insurance since 1984. Known as Medicare, it aims to provide 'fair and affordable' access to medical services for all Australians irrespective of their financial situation (Biggs 2004). Complementing this system is the Pharmaceutical Benefits Scheme (PBS), which subsidises prescription medications. The PBS was enacted in 1953, with some benefits having been available since 1948. This article considers the effects on equity of charging out-of-pocket expenses and, accordingly, reducing the 'fair and affordable' delivery of health care. In turn, it estimates the personal financial cost of these charges for Australians.

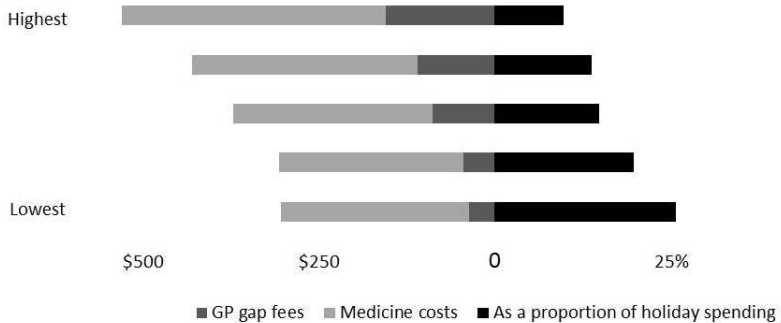
Such questions of accessibility and affordability are particularly pertinent in light of the controversial reforms to public health care announced in the 2014-15 Federal Budget. The Budget undermines thirty years of equitable health care policy by introducing a \$7 charge for primary health care (for more details, see Bunday's contribution in this volume). The figures presented in this article illustrate the burden already faced by Australians in accessing primary health care. In this context, an additional charge of \$7 for each visit to the doctor, pathology test or xray – even if it is only the cost of a third of a packet of 'ciggies' – is a cost burden that many Australians cannot afford. If passed by the Federal Parliament, this extra charge result in a person's level of social disadvantage becoming an even greater determinant of whether or not they access health care.

The Australian Institute of Health and Welfare (AIHW 2012) has identified age and social disadvantage as key determinants of poor health. While an individual's health needs generally increase as they age, social disadvantage is associated with poorer health at all ages which in turn means people will need to see the doctor more often. In some cases, levels of social disadvantage can mean these visits are postponed or avoided. There is

evidence that similar delays are made in having prescriptions filled. Delays are likely to compound the detrimental effects social disadvantage can have on a person’s health. The following snapshot of the cost of accessing health services also highlights the effect socio-economic status can have on the cost burden of health care.

The Australian Bureau of Statistics (ABS) regularly surveys household expenditure on goods and services in the *Household Expenditure Survey* (HES). The most recent survey confirms that age influences the amount a household spends on medical care and health expenses. In 2009-10 (ABS 2011) Australian households spent an average of \$389 per year on GP visits (\$85.80 after the Medicare rebate) and \$303.20 on prescription medication. Figure One below shows households in the lowest two income quintiles spent approximately the same on visits to the doctor and prescription medicine, with the amount spent increasing for the next three quintiles. There was a larger difference in the amount spent seeing a GP compared with expenditure on medication.

**Figure One: Medical expenditure by household gross income quintiles per annum**



Source: ABS (2011).

Figure One also shows household health expenditure as a proportion of money spent on holidays – a discretionary expense. Households in the top quintile spent ten times as much on holidays as they did seeing the doctor and paying for medication. This contrasts with households in the

lowest and second quintiles for whom medical costs represented a quarter and a fifth of the amount spent on holidays respectively. Unlike holidays, medical costs are not a discretionary expenditure. If out-of-pocket expenses mean that some Australians need to think twice about seeing the doctor, having a prescription filled or following up a referral then health care is not 'fair and affordable' for all Australians.

This article looks, in turn, at the incidence of out-of-pocket expenses incurred in seeing the doctor, having prescriptions filled and referrals for diagnostic testing. How government policy has tackled the issue of gap fees is then considered and options for regulating operational and procedural changes to address the issue are presented.

## **The Cost of Seeing the Doctor**

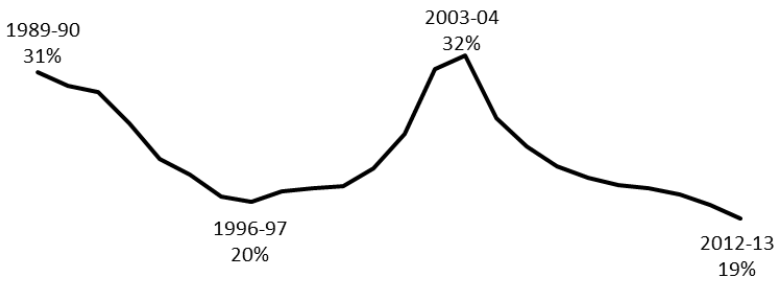
Private GPs, also known as the local or family doctor, are the primary health care providers for most Australians. When Medicare was introduced in 1984, a scheduled fee payable by the Commonwealth was set for visits to the doctor. While initially there was a limit on how much GPs could charge over the scheduled fee, this is no longer the case. This reliance on private GP services pits scheduled fees against profit motives. Recognition of this pressure is evident in the prohibition on private health insurance coverage for GP fees in order to prevent costs from ballooning.

A marked increase in the proportions of visits resulting in gap fees between 2000 and 2004 to levels previously seen a decade earlier generated talk of Medicare's demise (Schrader 2003). The rate of bulk billing has since returned to a level evident before this spike (as presented in Figure Two on the following page).

Figure Two shows that in 2003-04, gap fees were charged for almost one in three visits to the doctor. In response to this increase the government introduced incentives to encourage GPs to charge the scheduled fee (Medicare Australia 2010). This financial 'carrot' resulted in improved bulk billing rates. This improvement has been sustained, with only two out of ten patients (19 per cent) paying gap fees in 2012-13. The average amount paid by those people not bulk billed was \$28.58 per visit. There were 115,143,225

out-of-hospital GP visits (non-referred GP attendances)<sup>1</sup> in 2012-13, of which 21,762,070 visits resulted in gap fees being levied (Department of Health 2013a). Using the average out-of-pocket cost, it can be calculated that Australians paid \$615.9 million in gap fees for GP visits in 2012-13.

**Figure Two: Proportion of GP consultations<sup>2</sup> resulting in gap fees (1989-90 to 2012-13)**



*Source:* Annual Medicare Statistics, Table 1.4.

This burden is likely to be shouldered more by the aged and lower socio-economic groups as they are more likely to need to see the doctor. In an attempt to address this unequal burden, the Commonwealth provides a Pensioner Concession Card and Health Care Card to eligible people in receipt of Centrelink benefits. There is also a Commonwealth Seniors Health Card for people who do not qualify for the Age Pension but meet an income test. These cards do not, however, ensure that a person will be bulk billed but do increase the likelihood.

In addition to age and social disadvantage, women also face a higher burden from gap fees. Until retirement age women visit the doctor more frequently than men of an equivalent age (Parslow *et al.* 2004). ABS data show that

<sup>1</sup> Such visits would be subject to a \$7 charge from July 2015 should the health care reforms proposed by the 2014-15 Budget be passed by the Federal Parliament.

<sup>2</sup> Medicare statistics category: Non-referred attendances - GP/VR GP.

women made more visits (23 per cent) to the doctor during the two week survey period than men (18 per cent) (ABS 2012). The chance of younger women having to pay to see the doctor is further increased by the low number of women (14 per cent) aged 31-36 years who reported having a Health Care Card in 2009 (Women's Health Australia 2010). This situation means women are likely face greater disincentives when considering whether to make an appointment to see the doctor.

In 2008 more than one million Australians aged 15 and over had delayed seeing a GP due to the cost of the consultation (ABS 2010). The breakdown by age categories in Table One below shows that people aged under 45 years are more likely to put off making an appointment.

**Table One: Persons 15-64 years who did not visit a GP due to the cost (2008)**

Age	15-24	25-34	35-44	45-54	55-64	Total
<b>Estimated number</b>	224,600	272,500	257,200	175,800	107,000	1,037,100
<b>Proportion of population</b>	8 %	9 %	8 %	6 %	4 %	-

*Source:* ABS (2009), Table 2.2.

*Note:* Data for ages 65 and over have been excluded as the relative standard error is between 25% and 50%.

When Australians are forced to make health decisions based on how much it will cost it is evident that Medicare is not achieving the promise of affordable healthcare.

In 2004, the government introduced the Medicare Safety Net in response to the reduction in bulk billing. The current threshold for the Medicare Safety Net is \$1,221.90, after which 80 per cent of gap fees are reimbursed by Medicare. For concession card holders and recipients of Family Tax Benefit Part A, the threshold is \$610.70. Medicare records all scheduled expenses incurred by an individual, ensuring that, should they reach the Safety Net threshold, they automatically receive the increased rebates provided by the policy. Expenses incurred by a couple or family are not automatically

combined, requiring registration with Medicare before medical costs count toward a joint Safety Net threshold. It is important to note that only scheduled fees count toward the threshold, while any gap fees paid do not count.

There is a political agenda to significantly cut the number of Australians who do not have to pay to visit the doctor. In addition to a \$7 co-payment introduced in the 2014-15 Federal Budget, the Coalition Government has also reportedly left open the possibility that private insurers could be permitted to cover GP visits in the future (Tingle and Heath 2014). The proposed co-payment of \$7 for visits to the doctor has been criticised by the *Australian Medical Association* (AMA) because the concept could discourage people from visiting the doctor (ABC 2013). In effect, new co-payments will noticeably increase the number of people who need to pay out of pocket to see the doctor. Any expansion of private health insurance to include coverage for GP visits would see a ballooning in costs.

In addition to existing gap fees charged for a consultation, doctors can also influence the cost of prescription medications and the likelihood a patient will be required to pay for diagnostic testing when requested.

## **The Cost of Medication**

Further costs are faced by the millions of patients (11.3 million in 2009) who leave the doctor's surgery with a prescription for medication (ABS 2010). Of those with a prescription, nearly 70 per cent are likely to have repeat prescriptions (Newby and Robertson 2010), further multiplying the potential cost. Medications listed on the PBS are subsidised by the Commonwealth, with the public required to make a capped co-payment. The maximum co-payment paid by individuals is currently \$36.10 per prescription (though not all medications reach this cost threshold) and the co-payment for concession card holders is \$5.90 per item.

The cost of medication can deter some patients from having their prescriptions filled at all (NPS 2007). It has been reported in *The Medical Journal of Australia* that a third of Australians perceive the cost of prescription medications to be a 'moderate to extreme' burden (Searles *et al.* 2007). ABS (2010) data show that in 2008 almost one in ten people delayed purchasing or did not purchase the medication they had been prescribed because of the cost.

The co-payment a patient may have had to pay could have been inflated through the additional imposition of brand premiums and pharmacy mark-ups. At the time of writing the average brand premium payable for PBS listed medications was \$3.72 (Department of Health 2013b). Published data from 2009-10 shows that 16.7 million prescriptions were dispensed with a brand premium (PBPA 2010). Although the latest public data is three years old, the charging of brand premiums adds approximately \$62.1 million to the health care costs of Australians.

Savings are available, however, through the distribution of generic medications. A generic medication is a product that contains the same active ingredient(s) as a brand name medication but generally costs less. To be sold in Australia, generic drugs must meet the same standards as the branded alternatives with which they compete (NPS 2011). Although generic options are available for many prescription and non-prescription medications, those coming off patent enjoy brand recognition with GPs continuing to discuss and prescribe medication by brand name (CHF 2007).

The Commonwealth reduces costs on the PBS by only paying the lowest available price for a generic version of an off-patent drug to all companies manufacturing that medication. While these changes deliver benefits to the Federal budget, they do not necessarily offset prices paid by consumers. Drug companies are permitted to charge the public a brand premium and the PBS structure of capped co-payments does not restrict the amount people are charged through brand premiums or pharmacy mark-ups under the co-payment threshold.

Moreover, the price of medication also varies considerably between pharmacies. For example, the cost for the common antibiotic Amoxicillin<sup>3</sup> ranged between \$6.50 for a generic brand and \$12.00 for the branded Amoxil option (Fong 2010). The average price reported by the PBS was \$10.77. In the financial year 2009-10 there were 2.4 million units of this medication dispensed (PBS 2010) which adds up to \$25.8 million. If every prescription for Amoxicillin had been filled with a generic option costing \$6.50 Australians would have saved \$10.2 million.

The public's reported trust in doctors together with the prescribing habits they employ may help partially explain why generic medications accounted

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<sup>3</sup> Amoxicillin was the 17th highest volume drug on the PBS in the financial year 2009-10.

for only a third of dispensed medicines in 2008-09 (GMiA 2010). Public awareness campaigns for generic medications have suffered from budget restrictions and reluctance to encourage behavioural change. Funding for a 2007 campaign explaining the equivalency of generic medications was pared back in budget cuts announced in response to the global financial crisis (Australian Government 2008). A subsequent 2011 awareness campaign aimed to promote awareness of (a) active ingredients and how to identify their name, as opposed to the medication's brand name; and (b) that in some cases you can choose which brand of medicine you buy stopped short of encouraging people to switch to a cheaper generic option.

The Consumers' Health Forum of Australia (2007) has reported that consumers receive 'conflicting advice from pharmacists, medical practitioners and the media' about generic medications and are therefore 'reluctant' to choose generic products unless they receive 'specific advice' from their doctors or other prescribers. One in two patients would not use generic medication without first checking with their GP (NPS 2007). Doctors rarely discuss medication choice during consultations and, when it is, brand names are frequently used – a practice which tacitly reinforces the power of branding (CHF 2007). The prescribing practices of GPs show the proportion of generic medications prescribed by GPs varied only slightly in the decade to 2007-08, averaging 14 per cent of prescriptions (Britt *et al.* 2008). This low prescription rate amongst GPs is a determinant in the low market share held by generic medications and contributes to higher than necessary medication costs for people.

Possible resistance amongst GPs to increasing prescribing rates or raising awareness about generic medications may be due to the coercive influence of marketing strategies employed by drug companies. International research found that frequent visits to GPs by drug company representatives were associated with diminished generic prescribing practices. In a similar survey of 180 Australian GPs it was found that drug companies have an inappropriate level of influence over the prescriptions made by some GPs. This influence was found to outweigh the reported reliance on material produced by the National Prescribing Service (NPS) with only half the doctors surveyed reporting an awareness of this government body (Bray 2008). The AMA has also highlighted the influence of industry relationships with medical students. It found that these relationships can result in 'a preference for brand medications over generics' that persist beyond registration (2011). The potential for doctors to help Australians save on their



health bills by prescribing and promoting generic medications is undermined by the influence of pharmaceutical companies.

As the vendors of prescription medication, pharmacists can also influence the cost of prescription medication for the public. As trusted experts, pharmacists are in a position to drive an increase in the provision of generic medications, thereby delivering savings to individuals and the Federal budget. Government policy since 2008 has employed incentive payments to encourage pharmacists to promote generic medications. On 1 August 2010, the indexed incentive was \$1.56 per prescription or just under half the average brand premium (Medicare 2011b). The Auditor-General has reported that targeting an incentive policy at pharmacists as the dispensers of medication has resulted in an increase in the proportion of prescriptions being filled with generic drugs (Department of Health and Ageing 2010). This outcome occurred despite there being no significant increase in the rate at which GPs prescribed generic medications.

For those Australians whose medical conditions result in large medication costs additional support is available through the PBS Safety Net. The Safety Net offers additional subsidies for prescription medications once accumulated costs for prescriptions reach an annual upper threshold. The threshold is currently \$1,390.60 for non-concession card holders, after which the co-payment for PBS medications is reduced to \$5.90 (down from \$36.10). For concession card holders, the threshold is \$354.00, after which co-payments are no longer paid. Approximately a quarter (27 per cent) of PBS medications are dispensed through the PBS Safety Net (Medicare 2011a). Despite the intention of the Safety Net policy these thresholds may in practice be higher as brand premiums are excluded when calculating eligibility for the Safety Net.

There is some reason to question the success of this largely self-managed policy. The Auditor-General reported in 2010 that up to 144,000 people who were eligible for the Safety Net in 2007 did not apply and as a result missed out on accumulated savings estimated to be as much as \$10.8 million. The government has acknowledged that individuals are missing out on the intended benefits of Safety Net policies because they have neither enough information about either their eligibility to apply for them nor a clear understanding of how to keep the required records (ANAO 2010). Unlike the Medicare Safety Net which automatically registers expenses when a rebate claim is lodged, individuals are required to keep a record of the prescription

medications they purchase on the official Prescription Record Form as evidence they have reached the eligibility threshold

The limited uptake of generic pharmaceuticals despite the provision of incentives for pharmacists to supply them suggests that either the incentive is not high enough to offset the motivation of profits from branded medication or there is another obstacle. One such obstacle was only removed in 2008 when the National Health (Pharmaceutical Benefits) Regulations were changed to prohibit a default setting in computerised prescription software that checked the ‘no brand substitution’ box on prescriptions.<sup>4</sup> A study published in *The Medical Journal of Australia* found this amendment reduced from 27 per cent down to one per cent the number of prescriptions for antibiotics in which the ‘no brand substitution’ box was checked (Newby and Robertson 2010). This example highlights the potential that exists for government action to positively affect the amount Australians pay for medication.

There are existing computer programs for prescriptions that have an ‘equivalency’ function which lists all medication options that contain a specific active ingredient. Regulation that required a default setting that uses the active ingredient – except where the ‘no brand substitution’ box is marked – could have similar success to regulated changes to the default setting on brand selection (discussed above). Automatically prescribing medications by their active ingredient would reduce reliance on consumer awareness of generics and incentive payments to pharmacists with cost savings for individuals and the government.

## **The Cost of Diagnostic Testing**

When GPs seek additional information about a patient they request diagnostic testing with a referral. It has been reported that pathology tests are used in 70 per cent of clinical diagnoses (Britt *et al.* 2010). There is a Medicare fee schedule for diagnostic testing, but as with the scheduled fee for GP visits service providers may charge referred patients above the scheduled fee.

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<sup>4</sup> This box is available for doctors to check if they believe that changing the colour or shape of a medication may cause confusion for the patient.

The cost implications of diagnostic testing for the patient can be substantial. A 2001 study found that more than 15 per cent of Australians (an estimated 2.18 million people) did not undergo a recommended test, treatment or follow-up during the previous year due to the cost of that procedure (Blendon *et al.* 2002). Patients sent for such diagnostic testing potentially face an additional \$7 fee if measures included in the 2014-15 Federal Budget are passed by the Parliament.

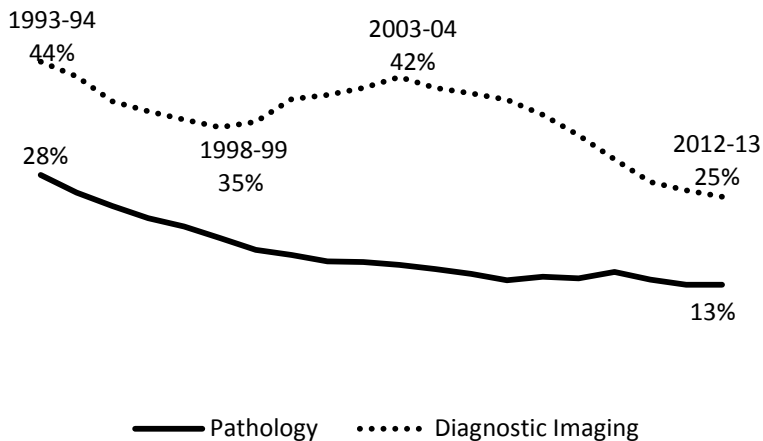
In 2008 referrals from health professionals led 8.4 million Australians aged 15 and over to have a pathology test and 5.4 million to have a medical imaging test (ABS 2010). Although the likelihood of being referred for imaging was lower the chance of being charged gap fees was higher.

Those patients who are not bulk billed for pathology tests face sizable gap fees. The AMA recommends charging fees for pathology tests that are almost twice the rebate provided by Medicare (Bray 2010). In 2010, gap fees charged for pathology services were reported to range from \$50 up to \$190. Medicare statistics report that there were 120.6 million pathology services in 2012-13, of which more than 2.7 million incurred gap fees (Department of Health 2013a). Therefore, the estimated value of gap fees paid lies somewhere between \$136.9 million and \$520 million.

Figure Three, on the next page, shows the proportion of pathology and diagnostic imaging tests billed at the scheduled fee in the past two decades. It demonstrates that while bulk billing rates had been increasing for both services there has been a lower rate of bulk billing for diagnostic imaging. This difference was fairly consistent up until 1998-99 when the rate of bulk billing for imaging decreased. The increase in people paying gap fees for imaging peaked in 2003-04 (42 per cent) after which time bulk billing rates began to return to earlier trend. It was not until 2009-10 that the earlier relationship with rates of bulk billing for pathology services was again achieved.

As with GP services the provision of pathology services is dominated by private providers. Private companies provide almost 90 per cent of Medicare funded pathology services (Sweet 2009). The government has, as part of reforms to the pathology sector, deregulated the collection market which has resulted in the opening of 'more than 1,000 new pathology collection centres' since July 2010 (Roxon 2011). The majority of public pathology services are based in public hospitals, however, this situation differs across state and territories. States offering higher levels of access to bulk billed

**Figure Three: Proportion of patients paying gap fees for pathology and imaging**



*Source:* Medicare Australia Statistics: Monthly and Quarterly Standard Reports, Table 4.

pathology include Western Australia, South Australia and the Northern Territory where private providers charge the scheduled fee for all pathology services.

The likelihood of being charged a gap fee for imaging is twice that for pathology. In 2012-13 there were 21.4 million Medicare imaging tests (Department of Health 2013a). One in four patients were charged gap fees for these tests. The peak body for private providers of diagnostic imaging, the Australian Diagnostic Imaging Association (ADIA), reported in 2010 that the average gap fee for medical imaging was \$66. More recently the ADIA noted that the gap fee patients pay is 'increasing at approximately 10 per cent per annum' (2013). On this basis, three years later the average gap fee is likely to be in the vicinity of \$88. Based on these figures, it can be estimated that \$471 million in gap fees were levied in 2012-13 for imaging tests. A report examining the quality of imaging services found that '[c]onsumers wanted informed financial consent before accessing medical imaging' (CHF 2010:6). Evidently some Australian's are unhappy with the levying of gap fees for diagnostic testing requested by their GP.

GPs use referral forms to order diagnostic tests for their patients just as they use prescription forms to prescribe medications. Unlike prescription forms, however, referral forms are often branded, effectively directing patients to a particular service provider. Consumer affairs research has reported that GPs ‘almost never discuss’ either the choice of service provider or the costs involved with patients (Bray 2010). Although a GP can request that a patient is charged the scheduled fee by checking a box on a pathology referral form a private provider may still overrule this request. The rate of bulk billing for pathology tests is higher than bulk billing for GP visits. This incongruity suggests that some GPs are willing to charge gap fees for their own services yet are happy to request that their patients are bulk billed for the pathology tests to which they refer them.

The influence of branded referral stationary has been partially addressed by legislative amendments passed in 2010. The *Commonwealth Health Insurance Amendment (Pathology Requests) Act 2010* facilitates increased choice for patients by removing the limitation on freely attending any pathology provider. Prior to this act, referring GPs were required to specify a pathologist in a referral request – a requirement conveniently met with branded forms. Though this requirement did not prevent an individual from then making an independent choice about which service provider to use, GPs were permitted to overrule independent choices.

In many instances diagnostic services can be accessed at no personal cost by going to publically funded providers. However, if GPs continue to use the branded referral forms supplied by pathology and imaging companies, patients are less likely to seek public services that would not put them out of pocket despite new legislation. Doctors have also faced pressure from for-profit pathology companies who have directly lobbied doctors to reduce bulk billing requests for pathology services unless they consider a patient to be in ‘genuine financial hardship’ (Creswell 2009). The government could counter this strongarm pressure by requiring the use of standard, unbranded referral forms (as used for prescriptions). While the new legislation gives individuals the freedom to take a pathology referral to any registered provider the continuing influence of branded referral forms means that the recent changes are unlikely to have any real effect unless branded referrals are also removed.

## Conclusion

A reliance on private providers for health services undermines the delivery of 'fair and affordable' healthcare through Medicare and the PBS. The pressure of profit motives on health costs is a burden on the Federal health budget and for individuals and families. Out of pocket expenses for GP visits, brand premiums on medications and diagnostic testing in 2012-13 is estimated at somewhere between \$1,296.7.9 million and \$1,679.8 million. In 2015-16, an additional \$1,130 million in out-of-pocket costs will be paid by Australians if the government is successful in introducing a co-payment for visits to the doctor and both pathology and imaging (Commonwealth of Australia 2014:133).

Additional costs are faced each time a service is charged over the scheduled fee or a brand premium is paid for medication when cheaper generic options are available. The market-orientated policy option of paying incentives to service providers, rather than regulating aspects of the referral or prescription process (which have been successful in the past) identified in this article, inevitably adds to the cost pressure on the health budget.

While governments may be historically tied to a model of private health provision, a choice between regulatory or market approaches to future operational and funding legislation and reform remains open. This article has identified viable operational and procedural changes that could be acted on immediately with positive outcomes for the health budget of households and the government.

*David Baker is Director of Research at the Australia Institute.  
davidb@tai.org.au*

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