



Submission to the Inquiry into Out of Pocket Healthcare Costs

May 2014

National Seniors

Australia

About National Seniors Australia

National Seniors Australia is a not-for-profit organisation that gives voice to issues that affect Australians aged 50 years and over. It is the largest membership organisation of its type in Australia with more than 200,000 members and is the fourth largest in the world.

We give our members a voice – we listen and represent our members' views to governments, business and the community on the issues of concern to the over 50s.

We keep our members informed – by providing news and information to our members through our Australia-wide branch network, comprehensive website, forums and meetings, bi-monthly lifestyle magazine and weekly e-newsletter.

We provide a world of opportunity – we offer members the chance to use their expertise, skills and life experience to make a difference by volunteering and making a difference to the lives of others.

We help our members save – we offer member rewards with discounts from thousands of businesses across Australia. We also offer exclusive travel discounts and more tours designed for the over 50s and provide our members with affordable, quality insurance to suit their needs.

Contact

Head Office

National Seniors Public Affairs, Level 18, 215 Adelaide Street Brisbane QLD 4001

P: 1300 765 050 F: (07) 3211 9339

E: policy@nationalseniors.com.au

W: www.nationalseniors.com.au

Table of Contents

Table of Contents

Introduction	1
Current and future trends in out-of-pocket health expenditure for older Australians (TOR a)	1
The impact of co-payments on consumers' ability to access health care (TOR b i)	3
The impact of co-payments on health outcomes and costs (TOR b ii)	6
The effects of co-payments on other parts of the health system (TOR c)	7
The implications for the ongoing sustainability of the health system (TOR d)	9
Key areas of expenditure, including pharmaceuticals, primary care visits, medical devices or supplies, and dental care (TOR e)	10
The role of private health insurance (TOR f)	11
The appropriateness and effectiveness of safety nets and other offsets (g)	13
Market drivers for costs in the Australian healthcare system (TOR h)	15

Introduction

Access to universal health care through Medicare is entrenched in the Australian public health system. This entitlement is highly valued by all Australians and contributes to our enhanced health status. However the cost of providing such access continues to escalate with the federal and state budgets increasing to meet the demand on the system.

Expenditure on health in Australia was estimated to be \$140.2 billion (9.5 per cent of GDP) in 2011-12, up from \$82.9 billion in 2001-02. The largest components of health spending were public hospital services (\$42 billion at 31.8 per cent of recurrent expenditure), followed by medical services (\$23.9 billion at 18.1 per cent) and medications (\$18.8 billion at 14.2 per cent).¹

Future government budgets will come under further pressure from increasing demand for health services. The Grattan Institute claims that rising healthcare costs are driven not by an ageing population alone but by people of all ages having more consultations, tests and operations; adopting new and effective treatments; and taking more prescription and other medications.²

As healthcare becomes more successful at managing acute and chronic disease, new ways of managing the health of the population and maintaining patients' independence in the community are essential to avoid escalations of chronic disease and unnecessary hospitalisations.

The Medicare budget in 2014_2015 is estimated at \$19 billion. Medicare is the third most expensive federal government program, after the age pension (\$39 billion) and family tax benefits (\$20 billion). Next year, Medicare will become the second most costly government program and by 2016-17, it is projected to cost more than \$23 billion each year³.

The aggregate Medicare gaps have grown on average by 11.7 per cent per annum between 1984-85 and 2011-12, reflecting the increasing costs of Medicare eligible services compared with the Medicare or private health insurance benefits paid.⁴

In spite of the high quality of health care in Australia, sections of the population experience difficulties in accessing affordable and timely health care.

Current and future trends in out-of-pocket health expenditure for older Australians (TOR a)

Australians aged 50 and over generally report financial stress in meeting the cost of their health care. In Australia, upfront health care costs comprise almost 20 per cent of health expenditure, are increasing at levels higher than CPI and are now the fifth highest in the world. Our average out of pocket healthcare costs of \$1,075 per annum are twice as much as in Britain or France.⁵

¹ Australian Institute of Health and Welfare 2014. *Health expenditure Australia 2011–12: analysis by sector*. Health and welfare expenditure series no. 51. Cat. no. HWE 60. Canberra: AIHW.

² Daley, J., McGannon, C., and Savage, J., 2013. *Budget pressures on Australian Governments*. Grattan Institute.

³ Bramston, T. Make or Break For Medicare 'The Australian' – Accessed 3February 2014
<http://www.theaustralian.com.au/opinion/columnists/make-or-break-for-medicare/story-fnbcok0h-1226816145677#mm-premium>

⁴ Australian Medical Association 2013. Key Health Issues for the Federal Election 2013. Canberra.

⁵ Australian Institute of Health and Welfare. 2013. *Australia's Health 2012*. Canberra.

Analysis of the 2009 Household Expenditure Survey conducted by the Australian Bureau of Statistics revealed slightly higher mean annual out of pocket expenses among older households at \$3,585 compared with younger households at \$3,377. However given that older households have lower personal incomes and greater access to concessional health care cards, expenses among these households indicate that health care costs are proportionately higher overall. This study included all private health insurance premiums which are the highest single cost for younger households, but are excluded from the above AIHW comparisons with other OECD countries.⁶

Research commissioned in 2012 by National Seniors Productive Ageing Centre revealed that 570,000 people aged 55 and over spend more than 10 per cent of their income on health while about 250,000 spend over 20 percent of their income on health. Expenditure of 20 per cent represents significant financial stress, particularly for people on low fixed incomes. On average, older Australians spend \$353 per quarter on out-of-pocket health care costs.

The burden is magnified for people with chronic health conditions as they tend to have lower incomes. Those with five or more chronic conditions spend \$882 per quarter which is almost six times as much as those with no chronic conditions.⁷

Member comments:

- 1. Aged pensioner aged 68. Having worked in the public sector for 24 years and paid taxes I feel that the health care costs are rising indirectly whilst general health care services in hospitals are not catering for the aged. My most recent out-of-pocket expenses include \$312 for specialist gap payments.*
- 2. We have private health insurance. That cost us about \$320 a month. So far this financial year for health care we have paid \$3,900 out of our own pocket. This includes glasses for my husband, dental appointments for both of us and a small operation for my husband which was not life-threatening (hence long wait list) but very painful.*

The *Healthy Communities* report on access to services across Medicare Local catchments in 2011–12 indicated that⁸:

- Adults who delayed or avoided filling a prescription because of cost ranged from 5 to 15 per cent.
- Adults who had been to a hospital emergency department in the period ranged from 8 to 29 per cent. Across metropolitan catchments, visits to emergency departments ranged from 8 to 15 per cent.
- The percentage of adults who were referred to a medical specialist and who felt they waited longer than acceptable for their specialist appointment ranged from 16 to 35 per cent.
- Adults who saw a medical specialist ranged from 22 to 42 per cent, and those who reported cost barriers to seeing a specialist ranged from 3 to 14 per cent.
- Adults who saw a dentist ranged from 29 to 66 per cent, while those who reported cost barriers to seeing a dentist ranged from 11 to 34 per cent.

⁶ Yusef F, Leeder SR. Can't escape it: the out-of-pocket cost of health care in Australia. *Med J Aust* 2013; 199: 475-478.

⁷ National Seniors Australia Productive Ageing Centre 2012. *The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face*. Canberra.

⁸ National Health Performance Authority, 2012. *Healthy Communities: Australians' experiences with access to health care in 2011–12*. Canberra.

The exclusion of dental care, allied health services and emerging treatments from universal health access under Medicare and the long wait lists for elective surgery all place pressure on the budgets of older Australians whose needs for such services increase with age.⁹

Older Australians are not hopeful of any improvement in affordability of their health care in the future. In a 2012 survey of 2,000 older Australians, only four per cent of people thought they would be more satisfied with Government spending five years into the future while 45 per cent thought they would be less satisfied and almost one-quarter were unable to state their opinion.¹⁰

Member comment:

As a carer I don't get access to some of the things that those I care for can get, like transport to medical appointments etc . My on-going need for psychology services is expensive. The need for Orthotics (\$900 a pair) that are supposed to last 5 years. Dental work and medications not on Medicare. These are just some of the out of pocket expenses we experience on a Carer's pension.

The impact of co-payments on consumers' ability to access health care (TOR b i)

In 2011-2012, a survey of 27,000 Australians and data from Medicare on health consumers' access to services in Medicare Local Areas around Australia revealed concerning levels of deferral of services due to cost. At least one in 10 residents in 32 areas put off either seeing a doctor or filling a prescription, or both, and 25 per cent or more of residents in 14 areas delayed or avoided seeing a dentist in the past year due to cost.¹¹

In 2012, approximately one-third of older Australians who participated in a National Seniors survey recorded affordability of health insurance and health care as primary concerns regarding health services in Australia. Survey participants' top three concerns included lack of access to Pharmaceuticals Benefits Scheme and Medicare Safety Nets (45 per cent), long waiting times for treatment (34 per cent) and staffing levels (30 per cent). These worries escalate with increasing age.

Additionally, older Australians continue to 'go without basics' including food, medicines and heating/cooling to make ends meet.¹²

Member comments:

- 1. I do not have private health care, I can't afford it and at 72 no fund is going to take me on. I have prostate cancer (treated with radiation ok), urinary incontinence due to TURP operation, Type 2 diabetes. I get 5 referrals from my GP per year which I use for podiatry (diabetes related) and the urinary incontinence. This is nowhere near enough for additional visits to the incontinence physiotherapist at \$58 x 3 or 4 a year. I estimate I am paying around \$2,000 a year not claimable.*

⁹ Martin, S., 2013. *Healthcare: Reform or Ration*. CEDA

¹⁰ National Seniors Australia Productive Ageing Centre. 2012. *Seniors Sentiment Index: A report by National Seniors Australia and Challenger*. Canberra.

¹¹ National Health Performance Authority, 2012. *Healthy Communities: Australians' experiences with access to health care in 2011-12*. Canberra.

¹² Kelly, S. (2011) *Are Older Australians Being Short Changed? An Analysis of Household Living Costs*. National Seniors Australia, November 2011.

2. *We have private health insurance and our GP told us that he has, for the first time, got patients who are not having elective surgery due to costs.*
3. *I have worked my later years as a nurse in General Practice, and it is not uncommon for seniors to avoid regular dental care because of its cost. Medicare Extended Primary Care plans giving 5 visits a year to eligible people help A LOT of people. Any reduction in access will really impact negatively on people in low-income brackets (not just seniors) accessing allied health care, especially psychology counselling for mental health, as it is a high-cost area.*
4. *Last year I was diagnosed with very aggressive prostate cancer. The first specialist diagnosis had a gap fee of \$256.25, and referred me to a Brisbane specialist surgeon. Non-refundable pathology costs were \$204.75. The surgery consultation in Brisbane was \$283.80 gap and the quote for surgery was \$12,634 with \$2405.60 being rebatable. We could not see how we could manage those costs. In addition, special 3D scan was required and further stress tests with a referred local group were quoted at \$560, non rebated amount of \$347.55 applying. (My local GP sent me to another clinic which did the tests for medicare costs). I am now attending a radiology clinic instead of surgery where the cost of about \$1200 to \$1600 is more within our ability to pay.*
5. *Ten years ago I was diagnosed with what was then considered inoperable prostate cancer. After radiation and hormone treatment life slowly got back on track. When the cancer returned two years ago I had to choose between hormone treatment effective for only a few years or a salvage prostatectomy which was performed only by a leading specialist surgeon. Some of the numerous scans were paid for by Medicare. The procedure's fees exceeded \$32,000. Fortunately the hospital component was covered by Health insurance. The specialist surgeon's own fee was \$14,000. When will Medicare be appropriately funded?*

Older Australians report that unaffordable medicines (44 per cent), a lack of financial means (35 per cent), a lack of information and advice (20 per cent), and lack of carer support/ assistance (13 per cent) are the most common types of difficulties experienced in accessing medicines.¹³

Twelve per cent of those aged 65 and over and a fifth (20 per cent) of Australians aged between 50 and 64 have also reported that they skip medication doses to counter mounting costs. Of this group, 41 per cent have sought cheaper alternatives, 21 per cent report rationing their pills and 18 per cent have not filled a prescription because of the financial strain.

Member comment:

I am 60 years old, female, still working in my own business, not earning a great lot of money. At times, I struggle to pay for my medications for diabetes type 2; plus one medication for cholesterol. In the past 12 months, I have not been able to pay for my medication on two or three different occasions. This only lasts for a week to ten days at most, but it does occur. I have no problems accessing health care services when needed; but have had to put off going to my GP for a week or so until I had the money to pay for the visit.

Financial strain associated with prescription medicines was reported by 17 per cent of people currently taking medicines and by 23 per cent of people who had used medicines in the last five

¹³ National Seniors Australia Productive Ageing Centre. 2012. *Seniors Sentiment Index: A report by National Seniors Australia and Challenger*. Canberra.

years. For those people aged between 50 and 64 years, these figures increase to 25 and 30 per cent respectively.¹⁴

Australia's universal health system is failing with evidence that people in low-income brackets and regional areas are less likely to be able to afford health care and more likely to delay seeking care in spite of poorer health status generally. In addition, older Australians on pensions and those with private health insurance are finding that out-of-pocket costs are unaffordable. Admission to hospital for private elective surgery at a high personal cost is often the only alternative for patients who wait to see specialists following placement on public elective surgery wait lists which effectively ration access to health services.¹⁵

Prior to the federal election, there was considerable media comment on proposals for a co-payment for GP services.¹⁶ National Seniors members were asked to comment on the possibility of paying a \$6.00 co-payment for bulk-billed GP services with a safety net that ensured pensioners and people on concessions cards were exempted and families with children would cease paying the co-payment after 12 visits. Responses indicated that people are aware of the increasing costs of Medicare services and that many, including pensioners are willing to make a small co-payment.

Member comments:

- 1. I support the co-payment because overall health costs are getting out of control and unless something is done, the whole Medicare system may collapse on itself. The most vulnerable – pensioners and concession card holders – would be shielded from the fee.*
- 2. A fee increase seems a reasonable proposition amongst other cost savings suggestions arising from the Federal Government's Commission of Audit.*
- 3. I am on a pension and would be happy to contribute \$6 if it meant I could get in to see the doctor when I needed to. If you cannot afford \$6 you need to look at your income stream or funds management even if on a pension.*
- 4. I would take it one step further and make a charge at emergency departments of hospitals for non-urgent cases that could have been dealt with at a surgery.*

Therefore National Seniors federal budget submission proposed the \$6 co-payment as a better alternative to an across the board increase in the Medicare Levy or the tax rate, each of which received considerable attention in discussion of forthcoming budgetary constraints. The GP co-payment proposed in our federal budget submission included a safety net which would ensure that people with concession cards and families with children under 16 would cease to pay the co-payment after 12 visits (\$72 out of pocket).

However the recent federal budget announcement of a \$7 co-payment for bulk-billed Medicare services widened the affected services to include pathology and diagnostic imaging services and increased the current co-payment for PBS prescriptions by \$5.00. In addition, the safety net which applies after 10 visits appears to apply to individual members of a family.

¹⁴ National Seniors Australia Productive Ageing Centre. 2012. *Senior Australians and Prescription Medicines: Usage, Sources of Information and Affordability*. Canberra.

¹⁵ Metherell, M, 2013. Australian healthcare: Out of pocket and out of date. *Journal of the Consumers Health Forum of Australia*. Issue 12, April 2013, p6.

¹⁶ Australian Centre for Healthcare Research, 2013. *A Proposal for affordable cost sharing for GP services funded by Medicare*. Submission to the Commission of Audit.

The impact of co-payments on health outcomes and costs (TOR b ii)

Respondents to a National Seniors 2009 survey stated that a lack of affordable access to doctors / specialists and health insurance, lack of government support for the health system, long waiting times and general ageing contributed to the deterioration of their health during recent years. People with five or more chronic conditions were significantly more likely to face a moderate (18.6 per cent) or severe (30.5 per cent) financial burden than those with fewer conditions.¹⁷

Member comments:

- 1. Having retired 3 years ago, I have continued with my existing health fund as in the near future I will be requiring a knee replacement. The surgeon could place me on the (public) waiting list. However the wait is approximately 3 years for a knee replacement. Remaining in the health fund, although I will need to pay out of pocket expenses, at least I will be able to have the knee replacement before it becomes extremely debilitating.*
- 2. I have tried to reduce my medications for this reason (cost) but there is only so far I can do that before it will impact on my health.*

In particular, people with multiple chronic health conditions are finding that the range of services and the number of occasions of service required to treat their condition/s can quickly impact on their ability to fund other living expenses. Households aged 50 and over report spending between 25 and 50 per cent of their disposable income on essentials such as groceries, transport, communication and medicine.¹⁸

Australians continue to report that they miss out on necessary health care due to financial barriers to accessing timely health services. Although bulk-billing of GP visits is greater than 80 per cent across Australia, bulk billing rates vary from 50 to 96 per cent across geographical areas and are not higher in areas with low socio-economic status.

Dental

People on low incomes have limited access to dental services due to the high costs of private services and rationing of public services which focus on emergency rather than preventative care. Consequently, this results in an escalation of dental problems among patients on the wait lists.

Many people aged 50 and older with chronic disease are unable to afford the cost of complex dental care. People aged 65 and older experience higher rates of oral health issues than younger groups, partly related to their higher levels of chronic disease.¹⁹

Member comments:

- 1. I am 60 and working. Having diabetes, dental care is a regular part of life. I have been very fortunate because I have found a dentist who lets me pay off my bill which is close to \$5,000 at \$50 a week.*
- 2. We have private health insurance but have put off dental appointments due to costs.*

¹⁷ National Seniors Australia Productive Ageing Centre 2012. *The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face*. Canberra.

¹⁸ Kelly S. *A squeeze on spending? An update on household living costs for senior Australians*. Melbourne; National Seniors Productive Ageing Centre: 2013.

¹⁹ AIHW 2012. *Australia's health 2012*. Australia's health no. 13. Cat. no. AUS 156. Canberra: AIHW.

3. *Can anyone tell me why dental is not included in helping pensioners? Do pensioners not have teeth and isn't teeth part of the overall treatment of health?*

Older Australians and Australians with complex medical health conditions such as cancer, HIV, hepatitis, mental illness and other chronic diseases are consistently identified as priority groups in great need of access to oral health care. Older Australians in residential care are also missing out on dental care which impacts significantly on their nutrition and general health.

The National Advisory Council on Dental Health's 2012 report estimated that a \$10 billion increase in dental care was required to address poor oral health in Australia, based on States and Territories caring for children and the Commonwealth caring for all adults (means tested).²⁰

Vision

Currently, there are more than 190,000 Australians aged 65 and older living with blindness, yet there is no national system in place to help them or those who are vision impaired. The government's Home Care packages are limited and targeted at frail aged and do not assist people with a disability. In spite of exciting advances in treatment such as bionic eye implants, nanosecond lasers and vision regeneration, older Australians continue to miss out on integrated models of care and prevention that could halt or reduce their vision loss.

Reading, vision and orientation technologies such as computer screen scanners, text readers, smart phones and tablets are expensive for people on fixed incomes, including pensioners. However the use of such technologies delivers cost-effective benefits for independent living and reduces health co-morbidities.²¹

Older Australians with severe vision loss face significant out of pocket costs for specialists, allied health services and technologies. In contrast, the Hearing Services Program provides free testing and hearing aids for concession card holders and Australians aged under 65 years with vision loss are supported through disability packages.^{22, 23}

The effects of co-payments on other parts of the health system (TOR c)

When access to treatment is deferred or compliance with medication is reduced, presentation to healthcare then occurs only when a condition has deteriorated significantly or when a person has higher levels of co-morbidity or experiences an emergency. This will increase presentations to emergency departments, resulting in avoidable hospital admissions at a greater expense than that of primary health care.

Member comments:

1. *As my body ages, I need more support from pharmaceuticals to maintain quality of life. The medications also prevent deterioration in health, which will cost the government more in primary health and hospital care if people can't afford the medications prescribed. (eg asthma, anti-hypertensives, anti-cholesterol drugs, steroids, and thyroid stabilising medications).*

²⁰ National Advisory Council on Dental Health, 2012. *Report of the National Advisory Council on Dental Health*. Canberra.

²¹ Centre for Eye Research Australia. *Visionary: Annual Report 2012*. Melbourne.

²² Centrelink <http://www.humanservices.gov.au/customer/enablers/centrelink/disability-support-pension/eligibility> accessed July 2013.

²³ Commonwealth of Australia. 2013. *DisabilityCare Australia: Brochure*. Canberra

2. *Governments at all levels should be investing proactively in the Health of their communities. By so doing, the requirement for expenditure in hospitals and treatment services will be lessened.*

Dental

Lack of timely attention to oral health problems can result in higher costs to the health system and merely shifts the costs to another part of the system. More expensive complex care is required with higher levels of hospitalisation and loss of productivity due to time off work or indirect impacts on the community for example, loss of contribution to family and community.

In February 2012, the National Advisory Council on Dental Health reported that poor oral health has an impact on individuals in terms of overall health, pain, nutrition, social exclusion and economic loss. Sub-optimal oral health also impacts on Commonwealth, State and Territory governments' expenditure through treatment of complex problems in hospitals and visits to GPs and pharmacists for treatment of pain and infection.

There is a well-established link between chronic periodontal disease and diabetes with poor management of each leading to a worsening of the other condition, and a weak but independent association with heart disease and respiratory disease in some studies. Diseases such as rheumatoid arthritis, stroke, chronic kidney disease and obesity where chronic infection may be an important factor have also been associated with periodontal disease.^{24 25}

Vision

Among Australians aged 40 and older in 2009, the major causes of vision impairment were age-related macular degeneration (AMD), cataracts, diabetic retinopathy, and glaucoma with half the cases of blindness attributable to AMD.²⁶

In 2010, the total economic cost of vision loss associated with AMD was in excess of \$5 billion. This includes health system costs, other costs to individuals and community, and loss of wellbeing. For every \$1 invested in the current treatment for wet AMD, there has been a \$2 saving in social benefit costs. In the absence of treatment and prevention efforts, the number of people with late stage macular degeneration (vision loss) could double from 167,000 to 330,000 by the year 2030.^{27, 28}

The lack of a national program for vision loss has a "snowball effect" on the health and wellbeing of older people, families, caregivers, and society. Higher absenteeism, premature retirement, and premature death are all more common outcomes among those with vision loss.²⁹ People whose

²⁴ Australian Institute of Health and Welfare 2012. Chronic conditions and oral health. Research report series no. 56. Cat. no. DEN 221. Canberra: AIHW.

²⁵ Dental Health Services Victoria, 2011. *Links between oral health and general health the case for action.* Melbourne.

²⁶ Access Economics Pty Limited June 2010. *Clear Focus: The Economic Impact of Vision Loss in Australia in 2009.* An overview of the report prepared for Vision 2020 Australia.

²⁷ Deloitte Access Economics & Macular Degeneration Foundation, 2011. *Eyes on the future - A clear outlook on age-related macular degeneration.*

²⁸ Macular Disease Foundation Australia. Brochures and Fact Sheets

<http://www.mdfoundation.com.au/page17334.aspx> accessed July 2013.

²⁹ International Federation on Ageing. *The High Cost of Low Vision: The Evidence on Ageing and the Loss of Sight.* Canada.

vision deteriorated from “normal” to blindness were nearly three-times as likely to need skilled nursing and be admitted to long-term care facilities.³⁰

The implications for the ongoing sustainability of the health system (TOR d)

In 2008–09, \$74.2 billion, or 64 per cent of total recurrent health spending, could be allocated to 18 broad disease groups.³¹ Cardiovascular diseases accounted for the greatest spending (11 per cent) followed by oral health (10 per cent) and mental disorders (8 per cent).³²

Sixty per cent of older Australians have a health condition that requires them to visit a doctor or specialist on a regular basis. The *My Communities* report on access to health services reported that the percentage of adults with long-term health conditions varied from 34 per cent to 60 per cent across Medicare Locals. Thus service planning of health care would be most effective when it reflects the needs of people in their local areas.³³

The *Australian Hospital Statistics 2012-13* report shows a continuing decline in public hospital capacity, particularly for patients aged over 65. Although bed-to-population numbers have been maintained over recent years, the increasing demand for hospital services and shift to more complex cases contributes to longer public hospital waiting times. In contrast, Australia's private hospitals have increased their capacity since 2009-10, with increased bed numbers to keep pace with demand. However their cases tend to be less complex than those of the public hospitals.³⁴

Respondents to the Seniors Sentiment Index survey of 2,000 older Australians identified several factors that impact on their health status. These included affordable access to doctors/ specialists and health insurance, exercise, quality of health care, lack of government support for the health system, long waiting times and general ageing.³⁵

Management of patients with chronic diseases would be enhanced by a more comprehensive approach to provision of health services and supports. An integrated patient centred focus could reduce progression of chronic disease to acute events and avoidable hospitalisations. This focus could include a move away from fee-for-service and greater reliance on multidisciplinary models of care.

Member comment:

Age Pensioner aged 68 years with five chronic conditions and out of pocket costs of \$560/month. I am doing the best that can be done to manage these conditions and keep them from worsening as much as possible, by maintaining an active lifestyle and undertaking proactive health and fitness training – physical, emotional and brain - and volunteering to deliver health promotion and education to community groups.

³⁰ International Federation on Ageing. *The High Cost of Low Vision: The Evidence on Ageing and the Loss of Sight*. Canada.

³¹ AIHW 2012. *Australia's health 2012*. Australia's health no. 13. Cat. no. AUS 156. Canberra: AIHW.

³² AIHW *How much do we spend on health?* Accessed 12 May 2014 at <http://www.aihw.gov.au/australias-health/2012/spending-on-health/>

³³ National Health Performance Authority, 2012. *Healthy Communities: Australians' experiences with access to health care in 2011–12*. Canberra.

³⁴ Australian Institute of Health and Welfare 2014. *Australian hospital statistics 2012 –13*. Health services series no. 54. Cat. no. HSE 145. Canberra: AIHW

³⁵ National Seniors Australia Productive Ageing Centre. 2012. *Seniors Sentiment Index: A report by National Seniors Australia and Challenger*.

Key areas of expenditure, including pharmaceuticals, primary care visits, medical devices or supplies, and dental care (TOR e)

Spending on health care in Australia continues to increase as a percentage of GDP (9.5 per cent of GDP in 2011-12) with Government funding almost 70 per cent of costs and the remainder from individuals, private health insurance, and other non-Government sources.

Between 2001-02 and 2011-12, funding by individuals grew by an average of six per cent a year in real terms, compared with an average of 5.4 per cent for total funding of health expenditure. Per person health funding by individuals grew at an average of 5.2 per cent per year from 2001-02 to 2011-12.

In 2011-12, individuals spent an estimated \$24.8 billion in recurrent funding for health goods and services. Over two-thirds (39.2 per cent) of this was for medications. A further 19.1 per cent was for dental services; 11.9 per cent for medical services; 10.1 per cent for aids and appliances; and 7.8 per cent for other health practitioner services.

The areas of expenditure with the highest per person growth rates in 2011-12 included benefit-paid pharmaceuticals (4.2 per cent) and dental services (2.2 per cent).³⁶ The lower proportion of benefit-paid pharmaceuticals (6.7 per cent) compared to all other medications (32.5 per cent) reflects the contribution of Pharmaceutical Benefits Scheme subsidies to affordable medications.

Member comments:

- 1. In the last financial year, the out-of-pocket health costs I have paid are: Pharmacy \$797.07, Medical \$258.25, Podiatry \$65.25, Physiotherapy \$131.00 and Miscellaneous \$370.00 a total of \$1621.57. On top of these health costs, the cost of contributions to my health fund were \$80.31 per fortnight, which is now \$85.27 from 1st April 2014.*
- 2. My wife and I have Private Health cover for hospitals and ancillary services and consider ourselves in good health. The annual insurance premium is \$4,117 after claiming the Commonwealth rebate. Out of pocket expenses in a year are over \$5,000 and include: Hospital - Generally no extra payment, GP's - go to bulk-bill doctors, also free flu injections, Specialists - Generally get about half back. Initial consultation up to \$400 for cataract checks and sleep apnoea, New Glasses - over \$200 with cheap frames, Dental - Sub-Total ~\$3,340 fillings are expensive and root canals and crowns about \$2,000. Cataract Operations - \$940. Sleep apnoea very expensive after benefits ~\$1,894.*
- 3. I have 4 chronic health conditions. I live in a regional area and very few doctors or specialists bulk bill. My GP consultation is \$59 of which I get \$32 back from Medicare - at least monthly to obtain a special authority script. The majority of specialists charge above the recommended fee - cost of a visit is \$110 of which I receive \$62 from Medicare. When I visit the Regional Imaging facility to have a CT, X-ray, MRI or Ultrasound, it is a battle to have them bulk bill me. The out of pocket costs would be between \$600/700. I honestly don't know how aged pensioners are expected to survive considering the possible cuts to aged pensions and \$6 to cover GP costs. My medications are quite costly as I take up to 11 medications twice daily. I also find the cost of \$6 per medication script difficult to handle some months.*

³⁶ Australian Institute of Health and Welfare 2013. *Health expenditure Australia 2011-12*. Health and welfare expenditure series no. 50. Cat. no. HWE 59. Canberra: AIHW.

4. *I have changed my dentist as they were charging a lot above the recommended fee and have now gone to a members first dentist. I am still out of pocket by \$60 most visits and sometimes up to \$120 depending on what is done. Optical costs are also hard to manage. So between all of the above, insurance charges for home, contents and car, there is not much left from each pension.*

For individuals with chronic or complex conditions, out of pocket payments can rapidly escalate because of gaps between the MBS rebate and fees for primary health, specialist, allied health, pathology and diagnostic imaging services. In addition, many patients face substantial health costs that are not supported by Medicare or the EMSN such as dental health services; low vision health services and assistive technologies; private allied health services; and in-hospital gap payments.

Member comment:

Often we have to fork out large sums to meet the gap not covered by Medicare or by private health insurance. Some prescription medicines are also not covered. Dental care is another matter. Our private health insurance really only covers basic checks up twice a year but the minute you need any other work done, it always costs more than the cover provided by private health insurance.

National Seniors research reveals that overall out-of-pocket expenditure increases steadily as the number of chronic conditions increased. Eighty per cent of 4,500 respondents to a 2009 survey had at least one chronic condition and 56 per cent had more than one condition. The presence and number of chronic conditions increased with age with five or more chronic conditions reported by twice as many (12 per cent) of those aged 75 years and over compared with those aged between 50 and 64 years. Out-of-pocket health expenditure was greatest for medication and medical services with cancer expenditure significantly higher than that for arthritis and high blood pressure.³⁷

This research reflects that of other studies; McRae reported that those with five or more illnesses spend on average five times as much as those with no diagnosed illnesses³⁸.

Member comment:

I find that fatigue and (five chronic) health problems restrict me from working the long hours I used to. I have private health insurance for hospital and extra cover. I access some public health services. My medical / dental expenses minus refunds amount to approximately \$2,200 a year. I obtain minimal tax benefit from this amount. I am also paying off \$7,500 for hearing aids over 3 years. I have Podiatry through Enhanced Primary Care for 5 visits, but I need to attend Podiatry every 4 weeks and obtain refunds from my health insurance other times. I also obtain refunds from my health cover for Optometry and spectacles. I am struggling financially at present due to the cost of health care and reduced income.

The role of private health insurance (TOR f)

Older Australians are committed to maintaining their private health insurance for as long as possible. The main reasons given by the over 50s for purchasing private health insurance are security, protection or peace of mind followed by choice of doctor, private treatment and shorter

³⁷ National Seniors Australia Productive Ageing Centre 2012. *The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face*. Canberra.

³⁸ McRae, I., Yen, L., Jeon, Y. H. et al. 2012. Comorbidity is associated with higher out-of-pocket spending: a study of older Australians with multiple chronic conditions. *Australian Journal of Primary Health*.

waiting times for treatment. People on pensions and allowances and lower income earners are more likely to report that they are unable to afford private health insurance.³⁹

However, their ability to contribute to the cost of their own health care and decrease the burden on the public health system is under attack due to rising out-of-pocket health costs, capping of Medicare rebates, the phasing out of the Net Medical Expenses Tax Offset, higher proposed thresholds for the Extended Medicare Safety Net and the recently announced changes to the private health insurance rebate.

Member comments:

- 1. Pensioners cannot afford to pay \$40-\$50 per week to be in a fund. I entered hospital under emergency situation relating to heart problems. I was told I was booked in for an angiogram for a week later but was told if I was a private patient I could have had it done the next day. Fortunately, I had a further serious attack the following night, whilst in hospital and that moved me up the list for the angiogram to be done the following day. Lucky me, could have been dead because I was not in a health fund.*
- 2. I have been in private health cover all my life transferring from my parents' family cover when I started work. Last year I had two operations Hernia and Prostate removal. My Prostate robotic procedure fee was \$4,000 for theatre set up of which no Health Fund paid a rebate. Both operations cost me over \$27,000. I was left with \$5,000 out of pocket expenses after health fund & Medicare benefits.*
- 3. My health fund has just announced another rise to \$128.60 per month. I am a single female aged 67 years. I am covered for private hospital and extras. The public hospital system here leaves a lot to be desired and one needs to have a choice of doctor as well. I am an aged pensioner and I am finding it increasingly difficult to keep up with private health fund costs. Also if I have to go to hospital I have to pay the first \$250 excess for any visit.*

The commitment of the Government to assist Australians with the cost of their private health cover is valued. As premium costs rise and the out-of-pocket fees increase for primary health, hospital and specialist health care, older Australians are foregoing important health care. This can only result in poorer health outcomes for seniors and cost shifting from the community to hospital settings.

Seniors have little capacity to increase their earnings to cover increased health insurance costs at a time when they are likely to require higher levels of care and are now faced with higher out of pocket costs before they can begin to access health services. Some are reducing their level of cover while others are opting to rely on the public health system with longer wait lists and deterioration in function and health status.

Member comments:

- 1. I am 70 and have been investigating health insurance because I have cataracts and the surgeon told me that I would not even be put on the waiting list until I was almost legally blind. A friend was badly injured waiting for surgery and her Dr told her that she should hope her name comes to the top before she is 70. Two other women were told that after 70 there was no chance of getting a hip or knee replacement. I expect to live for 20 more years and cannot afford insurance for that length of time.*

³⁹ National Seniors Australia Productive Ageing Centre. 2011. *A carrot and a big stick: understanding private health insurance and older Australians*. Research Monograph No. 1, October 2011.

- 2. We have private health insurance. That cost us about \$320 a month. It is most annoying to be paying out each month for health insurance and then finding that the gap is so big it is not possible to have things done anyway. We have put off dental appointments due to costs and our GP told us that he has, for the first time, got patients who are not having elective surgery due to costs. I guess for us it means if we spend on health we are not spending on something else and for some people that must be very hard and means going without essentials.*

There is an opportunity for private health insurers to contribute funding for prevention and early intervention to reduce incidence of chronic disease and progression of associated co-morbidities among their members. However this should not replace funding of Medicare services for the general population or for those who have chronic disease already.

The appropriateness and effectiveness of safety nets and other offsets (g)

The availability of concessions and safety nets is a key factor in supporting affordability of health care for those segments of the population who experience financial stress related to their health care costs. The Medicare and PBS Safety Nets, the MBS Chronic Disease Management Plans and the Commonwealth Seniors Health Card which assist with the cost of out of hospital services are highly regarded by older Australians.

The impact of safety nets and offsets on affordability of health care is demonstrated most starkly in the 2012 National Seniors Social Survey in which the highest level of financial strain was reported by 30 per cent of respondents aged between 50 and 64. People with low incomes and poorer health were most at risk of financial strain related to the cost of prescribed medicines while 31 per cent of people taking five or more prescribed medicines reported financial strain associated with their cost.⁴⁰

The proposal to increase the Extended Medicare Safety Net threshold by 60 per cent from \$1248.70 to \$2,000 for general patients is inequitable and hurts people who are living with chronic health conditions. Such an increase will have the greatest impact on the most vulnerable patients. The Extended Medicare Safety Net threshold for general patients should remain at the current level of \$1248.70.

National Seniors supports the need for Extended Medicare Safety Net benefit caps to be in place to prevent escalation in benefits when providers' charges are far higher than the MBS fee. However many members report that they face significant out of pocket costs for specialists charges which are higher than the Extended Medicare Safety Net benefit cap.

Member comments:

- 1. Currently, the safety net threshold is difficult for the average person to reach. The Scheduled fee needs a big overhaul as these fees have not kept in line with the growing costs of medicine.*
- 2. Out of pocket charges in the community pale into insignificance when compared with the huge out of pocket costs, bourn by those having procedures that entail hospitalisation and I am only talking about doctors charges. I recently had surgery where the doctor's fee was around \$9,500 and the combined Medicare and private health rebate was \$1,500. Surly this is an*

⁴⁰ National Seniors Australia Productive Ageing Centre. 2012. *Senior Australians and Prescription Medicines: Usage, Sources of Information and Affordability*. Canberra.

unrealistic situation. Shouldn't there be some type of separate safety net to cover these situations?

The increasing gaps between the Medicare rebate and the schedule fee, safety net caps and actual fees charged by GPs and specialists are causing financial hardship to consumers and limiting their access of required health services. The different eligibility and services criteria are very confusing for members of the public.

Therefore National Seniors welcomes the Federal budget announcement of the merging of Medicare Safety Nets from 1 January 2016. This is in line with our earlier recommendations to combine safety nets to better meet the needs of consumers, with chronic and complex diseases which require ongoing GP, specialist and pharmaceutical support. However the expansion of safety net caps to additional specified services will mean that consumers will face even higher out-of-pocket charges as any payments above the caps will not count towards the Medicare Safety Net.

National Seniors believes that substantial benefits would arise from a wider safety net for those with multiple chronic or complex conditions and targeted programs for lower income earners.⁴¹ Programs could be similar to current DVA arrangements whereby a practice or community nurse works with patients and supports doctors to reduced avoidable hospital admissions and reduce costs.

Member comment:

In a good system the cost of pharmaceuticals, GP. visits, physiotherapy, provision of medical supplies and devices and dental care should all be provided to those who can't afford them with appropriate support from tax payer dollars eg through a Medicare system with various moderator levels ..and .. dental care should be immediately included in Medicare.

The wind-down by 2014-2015 of access to the Net Medical Expenses Tax Offset for out of pocket health care costs will further exacerbate the financial pressure experienced by those retirees or low income workers who were required to submit a tax return. The rationale that the Net Medical Expenses Tax Offset was poorly targeted as it only supported consumers who submitted a tax return is contradicted by the proposed increase to the threshold for the Extended Medicare Safety Net. This increase targets all Medicare patients, regardless of their financial capacity to afford their health costs.

Although patients are grateful for the support provided under the MBS chronic disease management plans, the limit of a maximum of five allied health services per calendar year is insufficient to allow the ongoing treatment which many patients require.

Of particular concern is the requirement for single patients to reach the same threshold as a couple or family group. This inequity must be addressed. National Seniors believes that the thresholds for singles to access all health-related safety nets should be set at 66 per cent of that for couples or family units.

⁴¹ National Seniors Australia Productive Ageing Centre 2012. *The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face*. Canberra.

Member comment:

One of the biggest problems is the legalised discrimination against single people. Couples can combine their Medicare gaps to reach their comparatively lower threshold. While this may have some logic for young people with no family to support, it seems to be unfair to seniors who with advancing age are more likely to be both single and in need of medical care. I think the threshold for single seniors should be lower than for couples and other singles.

Market drivers for costs in the Australian healthcare system (TOR h)

Hospital costs are the largest component of public health expenditure and are growing at the greatest rate.⁴² The Grattan Institute estimates that \$1 billion of avoidable public hospital costs could be saved each year if hospital practices and performance were benchmarked against nationally efficient and effective prices.

The Government's spending on the Pharmaceuticals Benefits Scheme grew by six per cent a year in the five years to 2010-11.⁴³ Australians spent \$18 billion on medicines in 2010-11 including \$9 billion expenditure on the PBS for which the Government subsidies provided 80 per cent of costs.⁴⁴

The Grattan Institute also estimates that Australia could save \$1.3 billion a year, 14 per cent of the entire Pharmaceuticals Benefits Scheme budget if an independent board managed decisions on drug purchases within a capped budget, negotiated cheaper agreements with drug companies and increased the uptake of generic medicines.⁴⁵ Such an approach has been recommended in the recent Commission of Audit report.⁴⁶

Opportunities for restructuring the current system arise in responding to the challenges of an ageing population, chronic disease levels, improved technology and survival rates, and increased consumer expectations. A more effective health system would improve health outcomes across the continuum of care and deliver savings in hospital, primary health care and pharmaceutical services.

Member comments:

- 1. Australian and State Governments have greatly cut expenditure on health promotion (the preventive area) while being forced to spend increasing vast amounts of money on treatment for ill-health, now they are planning more cuts to both health care itself and considering reducing financial benefits to those like me on the Age Pension. This is morally bankrupt and financially ridiculous.*
- 2. Prevention is better and cheaper than cure. Educating and empowering people to take responsibility for their health and wellbeing will lead to healthier people and less cost in terms of hospital and treatment services. Healthier people make better people – better parents, partners and community members.*

⁴² Australian Institute of Health and Welfare 2014. *Health expenditure Australia 2011–12: analysis by sector*. Health and welfare expenditure series no. 51. Cat. no. HWE 60. Canberra: AIHW.

⁴³ Duckett, S.J. with Breadon, P., Ginnivan, L. and Venkataraman, P., 2013, *Australia's bad drug deal: high pharmaceutical prices*, Grattan Institute, Melbourne

⁴⁴ Australian Institute of Health and Welfare. 2013. *Australia's Health 2012*. Canberra.

⁴⁵ Duckett, S.J. with Breadon, P., Ginnivan, L. and Venkataraman, P., 2013, *Australia's bad drug deal: high pharmaceutical prices*, Grattan Institute, Melbourne

⁴⁶ National Commission of Audit, 2014. *Towards Responsible Government. The Report of the National Commission of Audit*. Commonwealth of Australia.

The current fee-for-service arrangement does not meet the needs of consumers with multiple, chronic complex conditions and has the potential to lead to increased throughput costs with little improvement in health outcomes. Primary health care could be more effective at reducing costs if patients with chronic and complex disease were enrolled in comprehensive packages of care with multidisciplinary teams.

Patients who are engaged in managing their health care are more likely to maintain and see value in the Patient Controlled e-Health Record.⁴⁷ A focus on increasing uptake among higher users of health care could reduce duplication of tests including pathology and radiology services as patients move between sectors of the health system.

The MBS Chronic Disease Management Plans are GP-managed, limit patients to only five referrals for allied health visits and follow-up is inadequate for many patients. A focus on rewards for maintaining health and prevention and achieving health outcomes rather than throughput is more likely to be consumer-directed and prevent escalation of chronic conditions.^{48 49}

Opportunities to widen the scope of practice of allied health providers have been suggested for many years with little uptake in Australia. There is substantial evidence across OECD countries of the effective use of pharmacists, practice nurses and physician assistants to deliver less complex health services at a reduced cost and to improve patient access.

Telehealth and assistive technologies have great potential to monitor the general health of patients with chronic and complex conditions and improve access to health services for people who are house-bound, in aged care facilities or living in rural and remote locations.⁵⁰

The National Health Performance Authority report on access to health care in 2011_12 concludes that the average health of local populations has little bearing on access to primary health care or other services.⁵¹ A combination of individual funding for chronic disease and complex patients and block payments for particular populations (as implemented in New South Wales, Ontario, New Zealand and the United Kingdom) would allow targeted programs to address priority health needs for particular demographics, risk factors and health status.⁵²

Member comments:

- 1. I am an aged pensioner who worked till 67 and have osteoarthritis. I have top health insurance with a fund which is usually generous with rebates. I had spinal surgery in a private hospital recently. My out of pocket expenses were still in the vicinity of \$2,500-\$3000. I am currently looking at bilateral knee replacement but have yet to work out if I can afford it. If I wait till I can have it done in a public facility I have little doubt that I would be dead first.*

⁴⁷ Greenhalgh, T., Hinder, S., et al., 2010. Adoption, non-adoption, and abandonment of a personal electronic health record: case study of HealthSpace. *BMJ*2010;340:c3111

⁴⁸ Carey, K, 2013. Australian healthcare: Out of pocket and out of date. *Journal of the Consumers Health Forum of Australia*. Issue 12, April 2013, p19.

⁴⁹ Taylor, N., 2013. *Healthcare: Reform or Ration*. CEDA.

⁵⁰ Brown, M, 2013. Australian healthcare: Out of pocket and out of date. *Journal of the Consumers Health Forum of Australia*. Issue 12, April 2013, p15.

⁵¹ National Health Performance Authority, 2012. *Healthy Communities: Australians' experiences with access to health care in 2011-12*.

⁵² Penno et al. How are population-based funding formulae for healthcare composed? A comparative analysis of seven models. *BMC Health Services Research* 2013, 13:470 Accessed at <http://www.biomedcentral.com/1472-6963/13/470>

2. *My wife is diabetic, has been in a wheelchair for around 6 years and needs a cataract operation. I am upset with the waiting time and reduced quality of life she has to endure before some-one sees her about her eyes.*

The health system stands to benefit from reforms which deliver improved productive, allocative and technical efficiencies. Examples include:

- Sharing client information, for example through the Patient Controlled eHealth Record to reduce duplication of services by providers.
- Enhanced scope of professional practice among allied health, pharmacists and nursing staff, especially in rural and remote areas could reduce demand for GP and specialist services.⁵³
- Ensuring hospital services are delivered using nationally efficient prices adjusted for regional differences.⁵⁴
- Improved outpatient clinics and surgical practices to reduce wait periods for elective surgery.
- Substituting cheaper generic medicines and more favourable purchasing agreements with drug companies would increase access to medicines.⁵⁵
- Enrolling consumers with chronic or complex conditions in bundled care packages with multidisciplinary teams delivering care coordination and more flexible consumer directed services.⁵⁶

⁵³ Duckett, S. and Breadon, P., 2013. *Access all areas: new solutions for GP shortages in rural Australia*. Grattan Institute.

⁵⁴ Duckett, S. and Breadon, P., 2014. *Controlling costly care: a billion dollar hospital opportunity*. Grattan Institute.

⁵⁵ Clarke, P. *The price is wrong: Pharmaceutical expenditure in Australia over the last decade and options for reform* in Committee for Economic Development of Australia. April 2013. *Healthcare: Reform or Ration* Melbourne.

⁵⁶ Mend Medicare Alliance. 2013. *Mend Medicare*.