TasCOSS

Tasmanian Council of Social Service

TasCOSS and TasMAG Submission to the Community Affairs Legislation Committee Inquiry into out-of-pocket healthcare costs

14 May 2014

The Tasmanian Council of Social Service (TasCOSS) is the peak body for the Tasmanian community services sector. Its membership comprises individuals and organisations active in the provision of community services to low-income, vulnerable and disadvantaged Tasmanians. TasCOSS represents the interests of its members and their clients to government, regulators, the media and the public. Through our advocacy and policy development, we draw attention to the causes of poverty and disadvantage and promote the adoption of effective solutions to address these issues.

The Tasmanian Medicare Action Group (TasMAG) was formed in November 2003 and is a coalition of individuals and organisations concerned about the erosion of Medicare and about the vulnerable state of our universal healthcare system. Our members comprise community sector organisations with an interest and involvement in the full spectrum of primary health care services and represent people on low to modest incomes across the state.

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Introduction

Thank you for the opportunity to contribute to this Inquiry. The Tasmanian Council of Social Service (TasCOSS) and The Tasmanian Medicare Action Group (TasMAG) wish to add our voices to those of the many other Australians who have in recent times publically opposed perceived attempts to diminish our universal healthcare system.

The Tasmanian Council of Social Service, other state Councils across Australia, and the national body the Australian Council of Social Service have long called for equitable access to healthcare and improvements in health outcomes for Australians living on low incomes.

The goals of TasMAG include:

- Maintenance of the principles on which Medicare is based: universality, equity, efficiency and simplicity;
- The extension of Medicare benefits to include dentistry, podiatry, physiotherapy, nursing and other essential healthcare services;
- Adequate funding for the public health system, and
- A commitment by state and federal governments to appropriate reforms to ensure that health spending is adequate and well targeted.

This submission addresses three of the Inquiry Terms of Reference, which are of particular relevance to the member organisations and the people living on low-incomes that we represent:

- the current and future trends in out-of-pocket expenditure by Australian health consumers;
- the impact of co-payments on consumers' ability to access health care, and on health outcomes and costs; and
- the appropriateness and effectiveness of safety nets and other offsets.

1. The current and future trends in out-of-pocket expenditure by Australian health consumers

Of all the states and territories, Tasmania has the highest proportion of population in the Socio-Economic Indexes for Area (SEIFA) most disadvantaged quintile. The health status of Tasmanians parallels that of people living in regional Australia and more generally in poorer socio-economic areas and as such is generally poorer than the health status of people in metropolitan or inner city areas.[1]

It is well established that areas of socio-economic disadvantage have correspondingly higher health risks, higher rates of preventable hospitalisation and

[1] Tas Govt, *State of Public Health* pp3-5; Tas Medicare Local *Primary Health Indicators Report*, p2

higher avoidable mortality rates – all evidence of health inequities relative to income (see Appendix A). There is in fact concern that the combination of the high risk factors associated with low SES demographics and an ageing demographic will increase the demand for treatment and care of chronic conditions,[2] and put a strain on the Tasmanian health care system.

This is not to suggest that the Tasmanian health system is in crisis; conversely, reports indicate that the system is "generally performing well".[3] General practitioners (GPs) provide a very good service in Tasmania: nearly 90% of respondents to a patient satisfaction survey reported that their GP listened carefully, showed respect and spent enough time with them.[4] The President of the Tasmanian branch of the Australian Medical Association, Professor Tim Greenaway, recently stated that through their frontline management of chronic disease Tasmanian GPs were contributing to the most efficient healthcare system in Australia[5] [See Appendix B].

Nevertheless, low income Tasmanians already find health care a financial burden. Our member community organisations consistently report that people who use their services are frequently unable to access bulk-billing GPs in Tasmania. While it is very difficult, given the discretionary nature of bulk billing, to find quantitative data that confirms or refutes this observation, we do know that in 2010 Tasmania had a lower than national average rate of bulk billing (74.7% in Tas, 80.2% nationally).[6]

Furthermore, since the introduction of the Extended Medicare Safety Net (EMSN) in 2004 —even with the introduction of capping in 2010—out-of-pocket expenses and prices of health services have increased.[7] Our members also report that many people in rural areas of Tasmania already struggle to cover the costs of transport to and from health care services. Tasmanian research indicates that faced with more pressing spending needs—housing, utilities, telecommunications, debt repayment and food—people on low incomes already effectively self-ration their medical spending.[8]

2. The impacts of co-payments on consumers' ability to access healthcare; and on health outcomes and costs

According to the Australian Centre for Health Research, in their initial proposal, the rationale underpinning a GP co-payment is to:

- Reduce the demand on GP services and allow them to focus on important presentations;

[2] Tas Govt, *Health Indicators* p3
[3] Tas Govt, *State of Public Health* p3
[4] Tas Govt, *Health Indicators* p174
[5] Mather, Anne p7.
[6] *Primary Health Indicators Report* p22
[7] Australian Institute of Health and Welfare (2012) "How Much do we Spend on Health?" Canberra: AIHW [web].
[8] Flanagan (2011) *The Price of Poverty*

- Reduce the moral hazard risk (i.e. make people think twice about attending the GP for minor ailments);
- Send a signal to consumers that GP services are not free;
- Send the message that we are each responsible for our own health; and
- Reduce incentives for GPs to over-service.

The overarching aim, therefore, is a reduction in the public spending on health through a reduction in demand. The Commission of Audit reflects this same sentiment, and recommends co-payment rates of $15.00/$5.00 pre threshold and $7.50/$2.50 post threshold for general patients and concession card holders accordingly.[9] The Federal Budget states the figure will be a $7 co-payment for GPs, and pathology and a $5 co-payment for pharmaceuticals.

However, many do not agree that GPs are currently overused. Australia-wide, the average rate of visits to the GP is 5.2 —well under the purported 11 visits per annum cited by the Commission of Audit.[10] Furthermore, it is clear that rather than decreasing healthcare spending and demand, a co-payment will more likely result in an overall increase in healthcare costs.

There is ample empirical evidence in Australia and overseas that demonstrates that cost deters people on low incomes from visiting the GP.[11] The Commonwealth Fund International Health Policy Survey found 16% of Australians surveyed reported having difficulties accessing health care services due to cost.[12] In Tasmania the figures are similar: 16% reported having difficulty accessing GPs, and cost of service currently rates in the top five barriers to access.[13]

A key reason why co-payments will ultimately result in higher healthcare costs is because early intervention and prevention is an effective means for reducing inequality and for containing healthcare costs.[14] Indeed, the Tasmanian Government Health and Wellbeing Advisory Council described the social and economic benefits of prevention as "profound".[15] A co-payment will not decrease health costs, but early intervention will.

One of the original architects of Medicare, Stephen Duckett, has been prolific in his public support for the economic value of preventative health and early intervention: "Making sure everyone can get primary care is an investment, not a waste, even if there are some proportion of visits that turn out to have been "unnecessary". In the long run, it saves money".[16] The Australian Council of Social Service warns that while the introduction of a GP co-payment is likely to lead to reduced visits to doctors, it

[9] *Towards Responsible Government: The Report to the Commission of Audit Phase One* p99.
[10] My Healthy Communities, GP attendances
[11] See, for example, Duckett (2014c); AMA President qtd in Knott and Harrison; Cate Speaks; and Costa, Con.
[12] Schoen et al
[13] Tas Govt, *Health Indicators* p174
[14] See, for example, Marmot, Michael (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010*. London: The Marmot Reviews, p18; Dwyer, John p12; and Doggett (2014) p15.
[15] Ministerial Health and Wellbeing Advisory Council *A Thriving Tasmania* p23.
[16] (2014b).

will also result in greater pressure on the hospital systems.[17] The Labor opposition spokesperson for health articulates this as such: "GPs are actually the cheapest end of the health system. They are experts at diagnosis and it is their job to pick up on potential health problems in their infancy. If this does not happen and people end up at the expensive end of the system—hospitals—there won't be any actual savings".[18] The Commission of Audit acknowledges that the introduction of a cost for GP visits will increase the load on (expensive) hospital emergency departments.[19]

The aim to "send messages" to people who access the GP unnecessarily is, at best, a risky healthcare strategy. It is the role of GPs to ascertain the severity of symptoms, injuries and illness. To place the burden of this onto unqualified members of the public is irresponsible and unrealistic. To send a message that says "stay home unless you are acutely unwell" will result in presentations to the GP that are beyond the preventative stage. Jim Gillespie makes an important differentiation between financial disincentives and the need for improved health literacy to decrease demand on GPs: "We need to improve health literacy and self-management but there is no evidence that this will occur through the financial pain of a $6 [$7] co-payment".

The impacts of the co-payments on Aboriginal health and wellbeing outcomes in Tasmania are particularly concerning, not only because Aborigines are over-represented in the low-income deciles, but also because of the removal of the capacity for GPs to waive the fee at their discretion (often enacted in times of financial hardship) and threats to funding of specific Aboriginal health care services in the Commission of Audit Report. This seems incongruous with the' Closing the Gap' strategy.

TasCOSS and TasMAG member organisations that provide preventative and primary Medicare services have also raised concerns about the practical difficulties of collecting a payment for services. For many, it is not administratively feasible to be collecting money from their clients. Services state that they are not prepared to refuse care for people who are unable to pay, nor would they willing to add to the debt burden of unpaid fees. To do so would be in direct conflict with the mission and objectives of many community health organisations.

3. The appropriateness and effectiveness of safety nets and other offsets

We support the principle underpinning the Extended Medicare Safety Net (EMSN): that individuals and families should be assisted with out-of-hospital services costs once an annual payment threshold has been reached through an 80% rebate. We

[17] ACOSS, Media Release 24th April.
[18] King, Catherine *The Conversation*
[19] p99.

are pleased to see that the lower threshold for Commonwealth Concession Card Holders and for people eligible for Family Tax Benefits Part A will not be raised in the proposed amendment to the EMSN Bill.

It is evident, however, that the Safety Net does not currently benefit people on low incomes, despite its intention to do so. The figures in the 2009 review of the EMSN disturbingly showed that 55% of EMSN benefits had been distributed to the top quintile of Australia's most socioeconomically advantaged areas, and that the bottom quintile received less than 3.5%. This is an enormous disparity, and means that ultimately the EMNS might be simply "helping wealthier people to afford even more high-cost services".[20]

The EMSN needs to better target people who have insufficient means to pay for substantial, on-going medical conditions; that is, those most in need of assistance. To facilitate a shift toward assisting those who most need it – low-income consumers who have long-term health costs - we support Jennifer Doggett's suggestion that the eligibility criteria for the EMSN be altered.[21] Instead of calculating eligibility solely on income, Doggett argues, people's income *and* their overall costs of long-term health needs should be considered so that the EMSN becomes more equitable and effective.

Final comments

In line with the principles of universal healthcare, access to and use of health services should not be in accordance with an ability to pay. Any moves toward the creation of a two-tiered health system, that exacerbates the already inequitable health outcomes for our more disadvantaged population, should be avoided. Instead, we advocate for maintaining measures that support the use of preventative, primary health care as a long-term, sustainable cost-effective option.

Our concerns are heightened by the broader context: a vulnerable system with increased health costs to those least able to afford them and yet most in need; cuts to the PBS; raising of the upper threshold of the EMNS; threats to super clinics and Medicare Locals; and proposed introduction of fees for public emergency departments by State and Territory Governments.

We cannot stress enough our support for a universal healthcare system that ensures that all Australians, regardless of ability to pay, have access to quality healthcare. Any erosion of this equitable and just system can only be detrimental to the health and wellbeing of the whole community.

Thank you again for this opportunity to lodge this submission. We are happy to provide you with more information on any of these points should it be required.

[20] Centre for Health Economics Research and Evaluation (2009) "Extended Medicare Safety Net: Review Report" Sydney: University of Technology Sydney [web]. P50.
[21] Doggett, Jennifer (2011) "Medicare Safety Net helps those that don't need it" *The Drum* 24 January, ABC [web].

Acknowledgements

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Reference List

Australian Centre for Health Research (2013) "A Proposal for Affordable Cost Sharing for GP Services Funded by Medicare" ACHR

Australian Council of Social Service. *COSS Health Priorities Statement: Equity in Access, Equity in Outcomes.* ACOSS.

Australian Government (2014) *Towards Responsible Government: The Report to the National Commission of Audit Phase One.* Commonwealth of Australia.

Australian Institute of Health and Welfare (2012) "How Much do we Spend on Health?" Canberra: AIHW.

Boxall, Anne-Marie (2014) "Medicare Turns 30 and begins to show Signs of Ageing" *The Conversation* 31 January, https://theconversation.com/medicare-turns-30-and-begins-to-show-signs-of-ageing-22390 [Accessed 23 April 2014]

Catherine (2014) "When $6 is more than you think" Cate Speaks Blog, 26th April http://catespeaks.wordpress.com/2014/04/26/when-6-is-more-than-you-think/ [Accessed 30 April 2014]

Consumers Health Forum of Australia (2013) "Analysis of the 2013-14 Federal Budget" Sydney: CHF.

Costa, Con (2014) "A $6 Co-payment is Mean Spirited and Impractical" *Doctors Reform Society* 22 April. Media Release.

Doggett, Jennifer (2011) "Medicare Safety Net helps those that don't need it" *The Drum* 24 January, ABC.

Doggett, Jennifer (2014) "First Steps to Better Value Health Care" *Health Voices*, The Consumers' Health Forum Issue 14, pp 15-16.

Duckett, Stephen (2014a) "Making the Rich Pay more isn't the Answer to a better Medicare" *The Conversation* 21 February, https://theconversation.com/making-the-rich-pay-more-isnt-the-answer-to-a-better-medicare-23477 [Accessed 23 April 2014]

Duckett, Stephen (2014b) "Save now, spend later: why co-payments for GP visits are a bad idea" *The Conversation* 23 April, https://theconversation.com/save-now-spend-later-why-co-payments-for-gp-visits-are-a-bad-idea-25823 [Accessed 23 April 2014]

Duckett, Stephen (2014c) "GP Co-payments: A Triple Fail for the Commission of Audit" *The Conversation* 2 May, https://theconversation.com/gp-co-payments-a-triple-fail-for-the-commission-of-audit-26195 [Accessed 7 May 2014]

Dwyer, John (2014) "A Better Health System for Fewer Dollars by Embracing Needed Reforms" *Health Voices*, The Consumers' Health Forum Issue 14, pp12-13.

Flanagan, Jo & Kathleen Flanagan (2011) *The Price of Poverty: The Cost of Living for Low Income Earners.* Social Action Research Centre: Anglicare Tasmania.

Gillespie, Jim (2014) "Mind the Gap: $6 GP Visit Proposal Ignores the Evidence" *The Conversation* 9 January https://theconversation.com/mind-the-gap-6-gp-visit-proposal-ignores-the-evidence-21754 [Accessed 24 April 2014]

Griffiths, Emma (2014) "Medicare co-payment: Peter Dutton fuels speculation ahead of budget of $6 fees" *ABC News* 23rd April. http://www.abc.net.au/news/2014-04-23/peter-dutton-fuels-speculation-of-medicare-co-payment/5406482 [Accessed 23 April 2014]

Jabour, Bridie (2014) "Palmer United Open to the Idea of a $6 Co-Payment for GP Visit" *The Guardian* 22nd April. http://www.theguardian.com/world/2014/apr/22/palmer-united-open-to-the-idea-of-a-6-co-payment-for-gp-visit [Accessed 24 April 2014]

King, Catherine "GP CO-payment would mean the end of Medicare" *SMH* 24 February. http://www.smh.com.au/comment/gp-copayment-would-mean-the-end-of-medicare-20140223-33ab3.html [Accessed 23 April 2014]

Knott, Matthew and Dan Harrison (2014) "$6 Bulk-Billing Fee Hits Poor, Spares Rich" *SMH* 25th April http://www.smh.com.au/federal-politics/6-bulkbilling-fee-hits-poor-spares-rich-20140425-zqzmy.html#ixzz308MO9baO [Accessed 30 April 2014]

Mather, Anne (2014) "Bulk-Billing Pain Feared: Tassie's most disadvantaged face $6 slug for visit to doctor" *The Mercury*, April 23rd, p7.

My Healthy Communities (2013) National Overviews, GP Attendances 2012-13. www.myhealthycommunities.gov.au/national/mbs0001 [Accessed 7 May 2014].

Schoen, Cathy; Robin Osborne; David Squires; Michelle Doty (2013) "Access, Affordability and Insurance Complexity are Often Worse in the US Compared to 10 Other countries" *The Commonwealth Fund*

http://www.commonwealthfund.org/Publications/In-the-Literature/2013/Nov/Access-Affordability-and-Insurance.aspx [Accessed 23 April 2014]

Tasmanian Government (2013) *Health Indicators 2013.* Hobart: Population Health, Department of Health and Human Services.

Tasmanian Government (2013) *State of Public Health 2013.* Hobart: Population Health, Department of Health and Human Services.

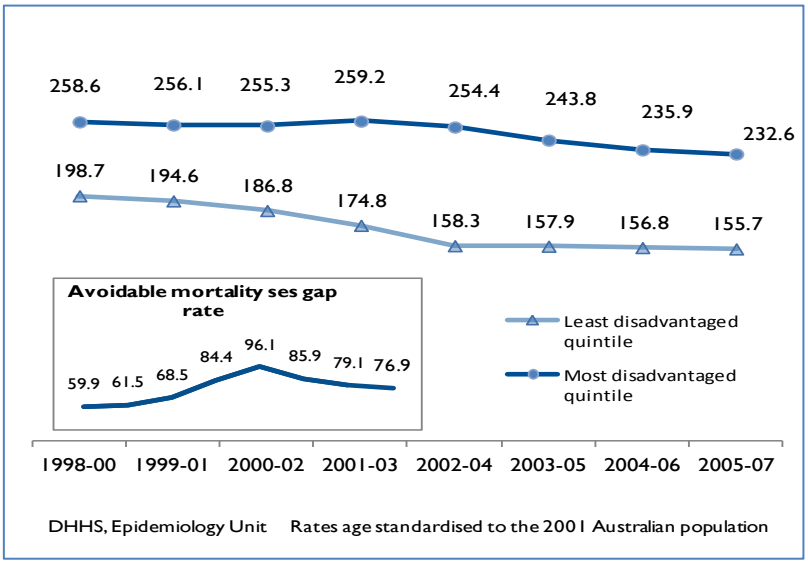
Tasmanian Government (2013) *A Thriving Tasmania: Final Report of the Ministerial Health and Wellbeing Advisory Council.* Hobart: Department of Health and Human Services.

Tasmanian Medicare Local (2012) *Primary Health Indicators Report,* Vol 5 Issue 1, Hobart: TML.

Appendices

Appendix A

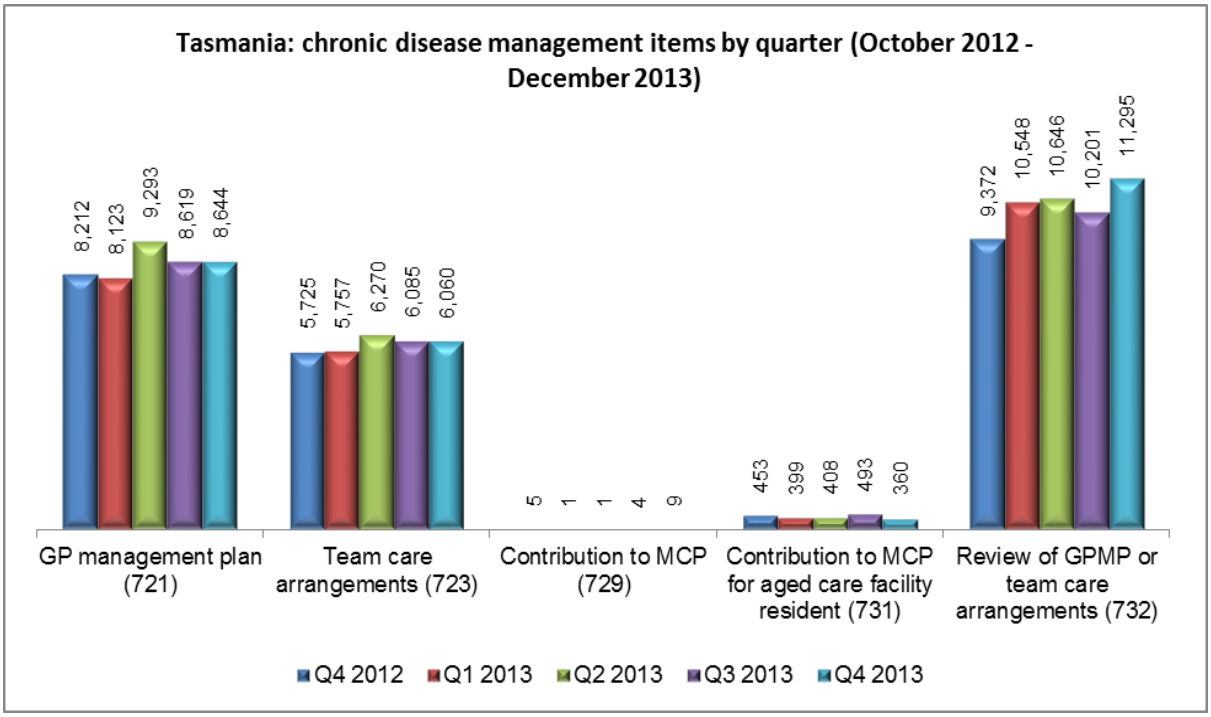
Avoidable death rate by SEIFA socio-economic disadvantage quintiles:



Source: Tasmanian Medicare Local (2012) *Primary Health Indicators Report* Vol 5 Issue 1, Hobart: TML, p5.

Appendix B

Recent Chronic Disease Management by GP in Tas:



Source: Tasmanian Medicare Local, unpublished data.