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Submission to the Senate Standing Committee Community Affairs References Committee

Inquiry into the out-of-pocket costs in Australian healthcare

12 May 2014

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

Introduction

The National Rural Health Alliance is comprised of 37 national organisations. It is committed to improving the health and wellbeing of the more than 6.7 million people in rural and remote Australia.

Members include consumer groups (such as the Country Women's Association of Australia and the Isolated Children's Parents' Association), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses and midwives, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and Frontier Services of the Uniting Church in Australia). The full list of Member Bodies is attached.

Each of the Member Bodies is represented on Council of the Alliance, which guides and informs policy development and submissions. With such a broad representative base, the Alliance is in a unique position to provide input on the broader issues relating to good health and wellbeing in rural and remote areas.

The purpose of this submission is to describe some of the particular non-metropolitan aspects of the out-of-pocket health care costs issue, to try to ensure that considerations relating to the matter comprehend the circumstances of people in rural and remote areas.

Overview

Households in rural and remote areas face particular challenges when it comes to meeting the out-of-pocket costs relating to health care.

Total out-of-pocket costs borne by a particular household are determined by:

- the health status of members of the household;
- the number of the household's costed interactions with the healthcare system which, in turn, is determined partly by the number of people in the household;
- the billing practices of the health professionals with whom members of the household interact, which is determined by decisions relating to bulk billing and gap fees, and the nature and type of the conditions or illnesses with which members of the household present;
- whether the household has private health insurance, which will be determined in part by the household's financial capacity;
- the cost of health-related goods, determined by commercial decisions (which might include an additional amount for transporting the item to the point of sale);
- regulation concerning the listing of items and the scheduled fees in both the Medical Benefits and Pharmaceutical Benefits Schemes;
- the existence of financial safety nets and the question of whether some or all members of the household are eligible for them; and
- the healthcare costs borne by members of the household that are not subject to safety nets.

This submission draws a distinction between the absolute level of out-of-pocket costs and their impact on particular families. People in regional areas pay more in standard, measured out-of-pocket costs than those in the Major cities. On the other hand, people in Remote areas pay slightly less per person per year, with those in Very remote areas paying considerably

less per person per year.[1] These absolute costs are kept at relatively low levels by poor access to health professionals and services. And the impact of a given level of out-of-pocket costs depends in large part by the financial situation in which a particular household finds itself.

The average out-of-pocket cost *per service received* increases from $5.01 in Major cities to $6.08 in Remote areas. However in Very remote areas the average out-of-pocket cost per service is considerably lower at $4.55, presumably due, in part, to the fact that a slightly higher rate of bulk billing applies in Very remote areas.

The average out-of-pocket costs *per head* to those who are not bulk billed is $29.94 in Major cities compared with $32.59 in Remote areas and $33.82 in Very remote areas.

Not only do families in rural and remote areas have lower incomes on average, but also they have poorer access to primary care. There is a so-called Medicare deficit of around $1 billion in rural and remote areas and an overall health care deficit of $2.1 billion a year.

Universal access to primary care is a critical and accepted goal of the Australian health care system. The system must therefore include the means to ensure that out-of-pocket costs do not work to limit people's ability to access primary care.

The three main means by which the impact of out-of-pocket costs can be mitigated are through private health insurance, accessing patient travel and accommodation schemes, and through the operation of MBS and PBS safety nets. Private health insurance is less affordable for country people and less attractive, given the relative paucity of private care facilities in areas where they live. The jurisdictional patient travel and accommodation schemes are poorly understood and promoted, and not sufficient to cover the real costs involved in travelling to and staying in major cities.

Whatever changes there are in their structure and operation, it is therefore critical that the MBS and PBS safety nets work effectively for people in rural and remote areas.

[1] Throughout this submission references to remoteness areas are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. For methodological reasons (eg small numbers) Remote and Very remote are often reported jointly. In the submission, references to "regional areas" mean Inner plus Outer regional; and references to "remote areas" mean Remote plus Very remote.

Out-of-pocket health care costs and rural and remote people

Out-of-pocket health care costs are financial payments made by consumers for accessing health care services and products that are not rebated by Medicare, private health insurance or other means. Latest evidence shows such costs to be 19 per cent of total health care costs nationally.

Overall, consumers or patients normally have to bear various proportions of certain health care costs, depending on the category. In broad terms it is 11 per cent of the costs of medical services, 17 per cent of the costs of pharmaceuticals listed on the PBS, 54 per cent of the costs incurred from service by other health practitioners, 67 percent of dental costs, 74 per cent of the costs of aids and appliances, and 97 per cent of non-PBS medicines.[2]

Between 2000-01 and 2010-11 payments for health services by individuals increased by 6.2 per cent per year - more quickly than the growth in payments by private health insurance funds (5.5 per cent per year).[3]

Examples of standard out-of-pocket health care costs are:[4]

- the 'gap' between the fee for a doctor's consultation and the amount rebated by Medicare;
- the 'gap' between the fee for a dental or allied health consultation and the amount rebated by a private health insurance fund (for someone with private health insurance);
- the total cost of a dental or allied health consultation (for someone without private health insurance);
- the cost of prescription medicines to the consumer (after the subsidy for PBS-listed medicines has been applied);
- the total cost of 'over the counter' medicines, such as aspirin and cough syrup;
- the total cost of natural and complementary medicines, such as vitamins and nutritional supplements; and
- the net cost of medical devices (after any subsidies and rebates are applied), such as prostheses, dental devices, syringes and contraceptives.

There has been some increasing focus on such payments in Australia, particularly because - at 19 per cent across-the-board - they represent a greater proportion of total health spending in this country than in many other developed nations. This increasing attention has been welcome, particularly because out-of-pocket costs discriminate against people in particular circumstances, including those who live in rural and remote areas.

This rural discrimination is caused largely by the fact that the unavoidable costs of travel faced by people in more remote areas are not measured and not considered part of the standard set of out-of-pocket health care costs. This is an important exclusion where people in rural and remote areas are concerned.

For example, the costs of accessing life-saving treatment for leukaemia for a primary school aged child from Outer regional NSW required the mother to relocate to Sydney with the child for the best part of a year, and for the father to quit his farm job to care for the child's four young siblings. Several tens of thousands of dollars were raised by two local clubs which

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[2] *Out-of-pocket: Rethinking health copayments*, Jennifer Doggett, Centre for Policy Development Occasional Paper Number 9, July 2009, http://cpd.org.au/wp-content/uploads/2009/07/Out-of-Pocket.pdf

[3] *Health Expenditure Australia 2010-2011*, AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737423003

[4] This list is from *Out-of-pocket: Rethinking health copayments*, Jennifer Doggett, Centre for Policy Development Occasional Paper Number 9, July 2009.

covered some of the costs involved. This demonstrates the sometimes extreme additional costs of accessing health services from regional and remote Australia.

Given that there is often a co-payment associated with each health consultation, another group who experience particular difficulties are those with chronic disease, because of the frequency with which they need care. Overall, rural populations have an estimated 26.5 per cent greater burden of chronic disease than populations in major cities, compounding the deleterious effects of out-of-pocket costs for rural and remote people.[5]

There are financial safety nets applying to both Medicare and PBS expenditures, and the Alliance has written elsewhere about the effect on rural people of lifting the amount to be paid under these prior to receiving benefits.[6]

People in rural areas have poorer access to health care. Because they have fewer encounters with the health care system, they may well incur less out-of-pocket costs than would be indicated by their clinical need for care. For example, because of their distance from a population centre large enough to support a pharmacy, some people have logistical difficulties in accessing medicines and pharmaceutical advice. This may result in rural and remote people spending less than their city cousins on over-the-counter medicines to treat minor conditions. Certainly it is the case that health card holders in rural and remote areas access the PBS less than card holders in the major cities.[7]

The extent to which people in rural and remote areas are already missing out on access to timely and affordable primary care is illustrated with reference to avoidable hospitalisations.

The age-standardised rate of potentially avoidable hospitalisations increases significantly with remoteness. For example, in 2011-12 the age-standardised rate of potentially avoidable acute and vaccine-preventable conditions ranged from 1,135 hospitalisations per 100,000 people in Inner West Sydney to 3,125 per 100,000 people in Central and North West Queensland.[8]

The general impact of higher out-of-pocket costs on health consumers can be judged from experience in medicines. Increases in medication co-payments primarily affect vulnerable populations such as those on low incomes and patients with chronic medical conditions taking multiple medications. To deal with increased costs, patients often reduce or stop taking their medicines and this can have potentially serious health consequences. This failure to take medicines can also lead to increased visits to the doctor and hospitalisations.

Increasing the patient's share of medication costs is associated with a decrease in adherence, which in turn is associated with poorer health outcomes.[9]

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[5] *Fact Sheet: Health promotion in rural Austalia* (2011) NRHA, http://ruralhealth.org.au/sites/default/files/fact-sheets/fact-sheet-05-health%20promtion%20in%20rural%20australia_0.pdf

[6] NRHA submission to Senate Inquiry into the Health Insurance Amendment (Extended Medicare Safety Net) Bill; April 2014.

[7] *Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas*, NRHA, January 2011, http://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/position/pos-full-complementary-report-27-feb-11.pdf

[8] *Healthy Communities: Potentially avoidable hospitalisations 2011-12*, National Health Performance Authority, http://www.myhealthycommunities.gov.au/Content/publications/downloads/NHPA_HC_Report_PAH_Report_November_2013.pdf

[9] Ortiz M., Are prescription copayments compromising patient care? *Aust Prescr* 2013;36:2-3.

In 2007 the AIHW reported: 'Compared to those in major cities, people in rural and remote areas have higher death rates from cardiovascular disease, but are dispensed these medicines at half the rate in rural areas [and] about one-thirtieth ***(sic)*** the rate or less in remote areas'.[10]

Some rural people already have reduced access to pharmacy services, such as medication counselling and Home Medicines Review, thus decreasing the likelihood of medication adherence, and increasing the risk of medication misadventure and avoidable hospitalisation.

Aggregate health expenditure in Australia

The Australian health system currently costs $132 billion per annum (excluding the cost of capital works), of which $59 billion is paid by the Australian Government, $33 billion by the States and Territories, $11 billion by health insurance companies, $25 billion by individuals and $5 billion by other entities such as third party motor vehicle and workers' compensation insurers (Table 1).

Table 1: Australian health expenditure 2011-12

	Common-wealth	State	PHI	Individ-uals	Other non govt	Total govern-ment	Total others	Total expendi-ture
	Billions of dollars							
Hospitals	19.5	22.9	6.3	2.5	2.3	**42.4**	**11.1**	**53.5**
Primary health care	22.6	7.1	1.9	17.2	1.8	**29.7**	**20.9**	**50.6**
Other recurrent expenditure	16.5	3.2	3.0	5.2	0.4	**19.7**	**8.6**	**28.3**
Total recurrent expenditure	**58.6**	**33.2**	**11.2**	**24.8**	**4.6**	**91.8**	**40.6**	**132.4**
Capital expenditure	0.3	5.1	Np	Np	np	**5.4**	**2.4**	**7.9**
Total expenditure	**59.0**	**38.3**	**Np**	**Np**	**np**	**97.3**	**43.0**	**140.2**

Note: np signifies not published
Source: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546631
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.
Out-of-pocket costs nationally amounted to $24.8 billion, or 19% of all recurrent health expenditure. This equates to an average contribution (for 23m. Australians) of $1110 per person per year.
If insurance premiums are included, out-of-pocket costs amount to $36B per annum, which is 27% of health expenditure, or $1610 per year per person.

Table 2 shows the costs borne by the various sectors (government, individuals, insurance etc) by the type of health care involved. The bulk of hospital costs are borne by government and insurance, whereas the bulk of the cost of primary care is shared between government ($29.7 billion out of a total of $50.6 billion) and individuals ($17 billion of that total).

[10] *Medicines for cardiovascular health: are they used appropriately?* (2007), AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454975

The stand-outs where the proportional contribution by individuals is concerned are other (non-PBS) medications ($8.07 billion out of $8.74 billion), dental services (individuals paid $4.74 billion of a total of $8.34b, and aids and appliances ($2.50 billion out of $3.69b).

Table 2: Australian recurrent health expenditure 2011-12 (in greater detail)

	Health Insurance funds	Individuals	Other non Govt	Total non Govt	Total Govt	Total expenditure
Hospitals	**Billions of dollars**					
Public	0.81	1.12	1.63	3.55	38.48	42.03
Private	5.48	1.33	0.70	7.52	3.96	11.48
Total hospital expenditure	**6.29**	**2.45**	**2.33**	**11.07**	**42.44**	**53.51**
Primary health care						
Non referred Medical services	0.00	0.64	1.13	1.77	7.88	9.65
Dental services	1.26	4.74	0.03	6.03	2.31	8.34
Other health practitioners	0.60	1.93	0.39	2.92	1.56	4.47
Community Health and other	0.00	0.12	0.15	0.27	6.83	7.09
Public Health	0.00	0.02	0.05	0.07	2.17	2.23
PBS benefit paid Medications	0.00	1.67	0.00	1.67	8.43	10.10
All other medications	0.05	8.07	0.08	8.20	0.55	8.74
Total primary health care	**1.91**	**17.17**	**1.83**	**20.91**	**29.71**	**50.62**
Other recurrent expenditure						
Patient transport services	0.18	0.35	0.10	0.63	2.37	2.99
Referred (specialist) med. services	1.2	2.32	0	3.52	10.73	14.25
Aids and appliances	0.49	2.50	0.07	3.06	0.63	3.69
Administration	np	np	np	1.10	1.29	2.39
Research	np	np	np	0.29	4.65	4.94
Total other recurrent expenditure	**2.97**	**5.17**	**0.44**	**8.59**	**19.67**	**28.26**
Total recurrent health expenditure	**11.17**	**24.80**	**4.60**	**40.56**	**91.83**	**132.39**

Source: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546631. np - not published.

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

Table 3 (below) shows total recurrent health expenditure for 2011-12 per Australian (includes men, women and children).

Table 4 shows details for out-of-pocket costs by geographic area. In terms of absolute dollars per year, out-of-pocket costs *per person* are highest in Inner regional areas and lowest (by far) in Very remote areas.[11]

[11] Tables 1, 2 and 3 are compilations of existing data produced by the NRHA for this submission. For Table 4 the Alliance has taken existing data and recalculated them.

Table 3: Australian recurrent health expenditure 2011-12, per capita expenditure

	Health Insurance funds	Individuals	Other	Total non govt	Govt total	Total expenditure
	Dollars per person					
Hospitals						
Public	36	50	73	159	1723	1882
Private	245	60	31	336	177	514
Total Hospital expenditure	**281**	**110**	**104**	**495**	**1900**	**2395**
Primary care						
Non-referred Medical services	0	29	50	**79**	**353**	**432**
Dental services	56	212	2	**270**	**103**	**373**
Other health practitioners	27	86	17	**131**	**70**	**200**
Community health and other	0	5	7	**12**	**306**	**317**
Public health	0	1	2	**3**	**97**	**100**
PBS benefit paid medications	0	75	0	**75**	**377**	**452**
All other medications	2	361	3	**367**	**25**	**391**
Total primary health care	**86**	**769**	**82**	**936**	**1330**	**2266**
Other recurrent expenditure						
Patient transport services	8	16	4	**28**	**106**	**134**
Referred (specialist) medical services	54	104	0	**157**	**480**	**638**
Aids and appliances	22	112	3	**137**	**28**	**165**
Administration	np	np	np	**49**	**58**	**107**
Research	np	np	np	**13**	**208**	**221**
Total other recurrent expenditure	**133**	**232**	**20**	**384**	**880**	**1265**
Total per head	**500**	**1110**	**206**	**1816**	**4110**	**5926**

Source: NRHA derived from AIHW and ABS population data. Note: np signifies not published.
http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546631
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.

Average per head out-of-pocket costs such as those in Table 3 must be considered in the context of the lower average household incomes and poorer health in rural and remote areas.

Comparing out-of-pocket costs between people in the Major cities and rural and remote Australia is difficult because the data is often thin and does not specifically compare city, rural and remote in a meaningful way. However, the Alliance has gathered and further

analysed existing published data so as to describe any meaningful differences between these areas. It has been possible, for this submission, to analyse non-referred health expenditure by region. This previously unpublished information is shown in Table 4 (below).

Table 4: Out-of-pocket [O-O-P] costs for non-referred attendances, by geographic area, 2011

	MC	IR	OR	R	VR	Australia
Non-referred services billed to Medicare (A)	92,228,861	24,527,659	10,739,691	1,295,930	609,430	129,510,112
Population (B)	15,992,076	4,162,976	2,047,681	318,814	206,707	22,728,254
Services per head per year (C)	**5.8**	**5.9**	**5.2**	**4.1**	**2.9**	**5.7**
Benefits paid (D)	$4,228,006,152	$1,120,805,509	$491,588,905	$61,996,017	$31,913,392	$5,939,320,311
Fees charged (E)	$4,690,021,141	$1,258,634,791	$552,086,200	$69,876,456	$34,683,269	$6,611,073,491
Total o-o-p (F=E-D)	$462,014,989	$137,829,282	$60,497,295	$7,880,439	$2,769,877	$671,753,180
O-O-P per person per year (F/B)	**$28.89**	**$33.11**	**$29.54**	**$24.72**	**$13.40**	**$29.56**
Average O-O-P per service (F/A)	**$5.01**	**$5.62**	**$5.63**	**$6.08**	**$4.55**	**$5.19**
Bulk billed services	76,795,121	19,528,815	8,646,183	1,054,125	527,533	106,637,332
Non bulk billed services	15,433,740	4,998,844	2,093,508	241,805	81,897	22,872,780
Av. O-O-P to non bulk billed person for each service	**$29.94**	**$27.57**	**$28.90**	**$32.59**	**$33.82**	**$29.37**
Bulk billing rate	**83.3%**	**79.6%**	**80.5%**	**81.3%**	**86.6%**	**82.3%**

Note: population data are ABS 2012 projections based on 2011 census (revised). Services relate to non-referred attendances (which includes GP/Vocationally registered GP, Enhanced primary care, other and practice nurse items (note that 89% of these attendances are to GP/VRGP). These non-referred attendances constitute 38 per cent of the cost of all Medicare billed services. Note that average out-of-pocket cost to non bulk billed person for each service refers to out of hospital non-referred services only (the bulk of non-referred services). The rest of the figures relate to non-referred services which are delivered both in and out of hospital.

Source https://www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02012-13?OpenDocument

The expenditures in Table 4 are those stemming from consultations with GPs (vocationally-registered and non-vocationally-registered), through Enhanced Primary Care items, Practice Nurse MBS items and 'Other' MBS items. In total such expenditures amount to $9.65 billion a year out of a total of $50.62 billion on primary care (see Table 2 above).

The number of non-referred services billed to Medicare, per head per year, follows a downward gradient from Inner regional to Very remote areas. People in Major cities received 5.8 non-referred Medicare services a year, there were 5.9 a year for those in Inner regional areas, falling to 2.9 per head per year for those living in Very remote areas.

The average out-of-pocket cost *per service received* increases from $5.01 in Major cities to $6.08 in Remote areas. However in Very remote areas the average out-of-pocket cost per service is $4.55.

82.3 per cent of non-referred services are bulk billed. The average out-of-pocket costs to those who are not bulk billed is $29.94 in Major cities compared with $32.59 in Remote areas and $33.82 in Very remote areas.

The average amount that an Australian pays out of pocket for non-referred services is $29.56 *per year*, while the average out of pocket cost for a person who is not bulk billed was $29.37 *per visit*.

Hospitals

About the same amount per head is spent in a year on hospitals ($2,395 per person) as on primary care ($2,266 per person).

Of the average per capita hospital expenditure, $281 was paid by health insurance companies, $110 as out-of-pocket costs by individuals and $104 by other non-government entities such as workers compensation and compulsory motor vehicle third party insurers. $1,900 in hospital costs per head of population was paid by Australian, State or Territory governments.

We are unaware of any data source which would tell us categorically how out-of-pocket contributions to hospital expenditure vary across regions (eg city v remote). However, we do know that there is lower per capita usage of private hospitals in regional and remote areas. This is presumably due to the lower prevalence of private hospitals in these areas, and to the lower average incomes and lower participation in private health insurance in these areas. Participation in private health insurance is around 57 per cent in Major cities, compared with 48 per cent and 41 per cent respectively in Inner regional and Outer regional areas.

The rate of private hospital use by people living in Inner regional, Outer regional, Remote and Very remote areas reflects these rates of private health insurance. It is respectively 77 per cent, 60 per cent, 53 per cent and 39 per cent of the rate for people living in Major cities.[12]

Private hospital expenditure tailed off rapidly with remoteness: from $346 per person in Major cities in 2011-12, to $313, $235, $158 and $102 per person living in Inner regional, Outer regional, Remote and Very remote areas.

However the reverse is true for public hospital usage. In 2006-07 the rate of public hospital admission/separation increased with remoteness to twice the Major Cities rate in remote areas. Total expenditure on public hospital admissions was 10 per cent and 30 per cent higher for residents of Inner Regional and Outer Regional areas, and roughly twice as high for residents of remote areas.

The net effect was for lower overall rates of hospitalisation in Inner Regional areas, but 2 per cent higher in Outer Regional areas, 12 per cent higher in Remote, and 56 per cent higher in Very remote.[13]

Bulk billing

The rate of bulk billing for the services of general practitioners, including for enhanced primary care and practice nurse item numbers, is 83.3 per cent in the Major cities and 79.6,

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[12] *Australian hospital statistics 2012-2013*, AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547000

[13] *Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas* (2011), NRHA, http://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/position/pos-full-complementary-report-27-feb-11.pdf

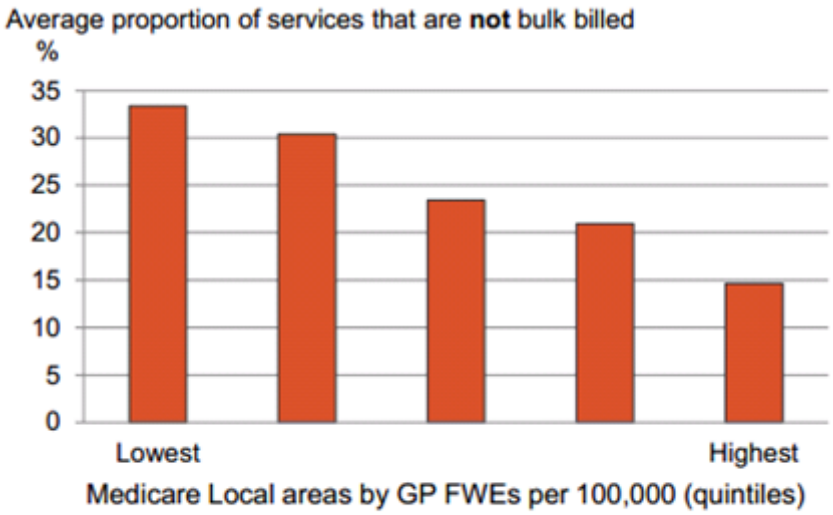
80.5, 81.3 and 86.6 per cent respectively in Inner regional, Outer regional, Remote and Very remote areas respectively (see Table 4).

It should be noted that although people in Very remote areas are bulk billed more often, when bulk billing is not applied, people in Remote and Very remote areas pay a greater co-payment than those in Major cities and regional areas.

On average, people in the worst-served areas pay out-of-pocket costs (that is, they are not bulk billed) more than twice as often as people in the best-served areas (see Figure 1 below).[14]

The factors which influence a GP's decision to bulk bill include whether they believe the Medicare benefit adequately reflects the costs and complexity of their practice, and the level of competition in the market for general practice services.

Figure 1: Services that are not bulk billed, Medicare Locals, by access levels, 2010-11



Note: Averages for Medicare Local quintiles are population adjusted. Source: Grattan Institute, based on Department of Health and Ageing (2012)

Many believe that Medicare rebates do not take account of the higher costs and increased complexity of rural practice relative to urban areas.

Practitioners exercise discretion in charging gap fees, often recognising the socioeconomic status and financial need of individual patients. Many GPs and specialists have a sliding scale where those on very low incomes to be bulk billed with no gap.

If they want their patient to have access to Medicare, optometrists are bound by an agreed fee for service and currently cannot charge a gap fee. Like others, optometrists argue that the indexation of Medicare rebates has not kept up with inflation. Their practice is to bulk bill at a loss on a case by case basis when a patient cannot afford to pay. Flexibility is needed in order for them to remain financially viable.

[14] *Better access to GPs and primary care: who do you trust?*, NRHA, http://www.ruralhealth.org.au/news/better-access-gps-and-primary-care-who-do-you-trust

The particular impact of out-of-pocket costs in rural and remote areas

> *"All members of my household pay their own private insurance but ironically, on very low incomes, can't afford to access appropriately timely medical attention. On my own account, I avoid visits to the dentist because of the high level of out of pocket expenses. With a multitude of complex chronic conditions, affording my own health care is a challenge: financially and emotionally."*

The volume and value of out-of-pocket health care costs may be quite unrelated to a household's actual need for health care. Given their unequal access to healthcare professionals, the people of rural and remote areas are more likely than those in major cities to have clinical need for an amount of care that is under-stated by per head expenditure on health and health-related services - both from their own pocket and through the public system.

The main reason why high levels of out-of-pocket costs are a serious problem for the health sector is that they prevent some people from accessing primary care in a timely fashion. This means that they are receiving poorer or inappropriate care and have as a result poorer health outcomes than would otherwise be the case.

The case made in this submission is that this affects people in rural and remote areas more seriously than their cousins in major cities.

Given the greater price-sensitivity of people in rural and remote areas, a Medicare co-payment might have a particularly negative impact on access to GPs for people in those areas. Flat co-payments are regressive: the lower the person's income, the higher the proportion of their income a co-payment will be. Out-of-pocket health care costs, of which co-payments are a part, therefore have the greatest negative effect on those on lowest incomes.

Flat co-payments are especially perverse because not only are poorer people less able to afford them, but they are also much more likely to have poorer health and need access to health services.

The private sector, of which general practice is a part, cannot provide fair access to services where markets are thin, as in many parts of rural and remote Australia. Consequently, a growing number of people in those areas are missing out on local access to primary care. This is contributing to the situation in which the inverse care law[15] is particularly evident in rural and remote areas.

Reports published by the AIHW and the Alliance show a primary care deficit in rural areas in 2006-2007 of at least $2.1 billion, reflecting the maldistribution of doctors, pharmacists, allied health services and dentists.[16]

Most significant in this deficit is the extent to which people in those areas are missing out on access to no-cost or low-cost treatment from a general practitioner. This is measured by reference to the so-called Medicare deficit. Wherever one lives, "No doctor means No Medicare". In 2006-2007 there was a deficit of $811 million in MBS benefits paid for all

[15] "the greater the need, the less health care received"

[16] *Australian healthcare expenditure by remoteness: a comparison of regional, city and health expenditure, AIHW, 2010. Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas*, NRHA, January 2011

services to rural people. When adjusted for increased population and current prices, this represents a current shortfall of over $1 billion per annum.

This one deficit can be re-stated as an absence of services. In 2006-2007, the people who live in regional and remote areas experienced a shortfall of 12.6 million MBS-funded services. And at this rate, this service shortfall will be repeated every year.

Avoidable hospitalisation

One of the impacts of missing out on primary care is a higher rate of avoidable hospitalisation.

The age-standardised rate of potentially avoidable hospitalisations increases significantly with remoteness. For example, in 2011-12 the age-standardised rate of potentially avoidable acute and vaccine-preventable conditions ranged from 1,135 hospitalisations per 100,000 people in Inner West Sydney to 3,125 per 100,000 people in Central and North West Queensland.[17]

Not only does the rate of potentially avoidable hospitalisations increase with remoteness, but so too does the length of stay for patients. Rates of overnight separation increased with remoteness to almost double the Major Cities rate for residents of Very Remote areas. As a result, rates of expenditure on overnight separation increased with remoteness - expenditure per Very Remote person being double that of a Major Cities resident. Overall, the Alliance estimates that people outside the Major Cities had about 190,000 more overnight services than if Major cities rates had applied.[18]

An Australian Bureau of Statistics (ABS) survey found that those living in Outer Regional, Remote and Very Remote areas of Australia were more likely to visit an emergency department compared with those living in major cities (17.1 per cent compared with 12.3 per cent).[19]

Low income

Low income is a serious and pervasive problem in rural and remote areas. In aggregate, incomes in regional areas are some 20 per cent lower than in major cities.[20] On top of this, many goods and services are more highly priced in rural areas. For example, in 2005, the AIHW identified food costs as being 10-20 per cent higher in rural and remote areas, with petrol frequently being 10 per cent more costly in these areas. More recent figures confirm these price differentials.

Despite the common perception that housing in rural and remote areas is cheaper than in the major cities, people in rural and regional Australia are in fact more likely to experience housing stress. In some states, energy costs are higher in regional than metropolitan areas, with many financially-vulnerable people facing serious difficulty coping with energy bills.[21]

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[17] *Healthy Communities: Potentially avoidable hospitalisations 2011-12*, National Health Performance Authority, http://www.myhealthycommunities.gov.au/Content/publications/downloads/NHPA_HC_Report_PAH_Report_November_2013.pdf

[18] *Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas* (2011), NRHA, http://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/position/pos-full-complementary-report-27-feb-11.pdf

[19] *4839.0 - Patient Experiences in Australia: Summary of Findings, 2012-13* (2013), ABS, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4839.0main+features62012-13

[20] *A snapshot of poverty in rural and regional Australia* (2013), NRHA, http://ruralhealth.org.au/document/snapshot-poverty-rural-and-regional-australia

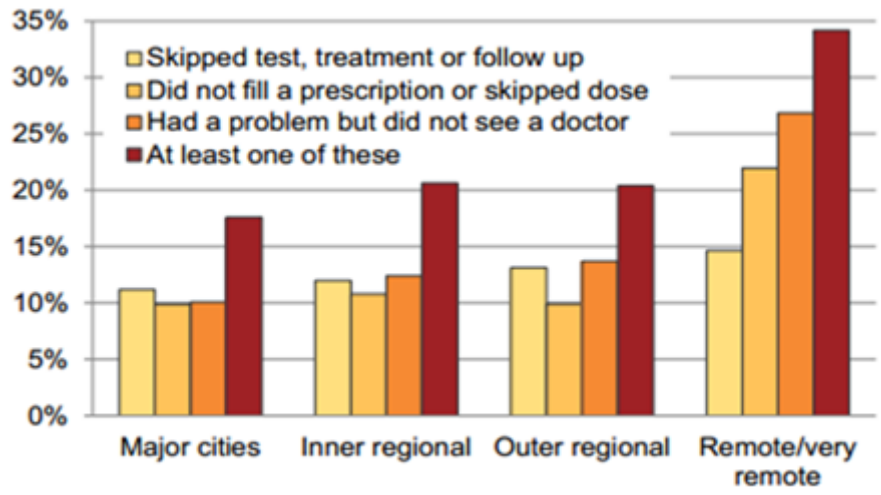
[21] http://ruralhealth.org.au/documents/publicseminars/2013_Sep/Joint-report.pdf

> *"There have been examples of young mothers in rural areas, particularly those on low incomes, having to decide whether to go to the pharmacy or purchase the bread and milk for the day."*[22]

Having lower incomes, low total out-of-pocket health care costs are likely to be more difficult for a rural household to pay. The National Centre for Social and Economic Modelling (NATSEM) found that households in rural Australia allocated a slightly higher proportion of weekly expenditure to health items. This occurred across the range of health goods and services.[23]

Perhaps because of their lower incomes and other (non-health) pressures on their income, people living in a more remote area are more likely to report that they skip visits, treatments, tests and medications because of cost (see Figure 2 below). (Another possibility is that cost may be perceived as being the issue when in fact it is something to do with their cultural attitude to healthcare services and/or the logistical difficulties of accessing them.)

Figure 2: Proportion of people who reported access barriers due to cost in the last year, by remoteness, 2010



The same is true for dental care. The AIHW has reported that the cost of dental care (predominately provided in the private sector) was also preventing a significant number of people from accessing necessary services.[24] People living in Outer regional, Remote or Very

[22] Marg Brown, President of Health Consumers of Rural and Remote Australia.
[23] *Distribution of Expenditure on Health Goods and Services by Australian Households* (2008), NATSEM, http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/NATSEM%20-%20Distribution%20of%20Expenditure%20on%20Health%20Goods%20and%20Services%20by%20Australian%20Households.pdf
[24] Australian Institute of Health and Welfare (AIHW), *Trends in access to dental care among Australian adults 1994-2008*, cat. no. DEN 205, AIHW, Canberra, ACT, 2011, http://www.aihw.gov.au/publication-detail/?id=6442472418

remote areas of Australia were more likely to delay or not visit a dental professional due to cost (21 per cent) compared with those in Major cities (17 per cent).[25]

The Figure above is a clear indication of one of the challenges for governments and policymakers: to ensure that all Australians, irrespective of where they reside, continue to have equitable access to high-quality, affordable primary health services.

Travel costs

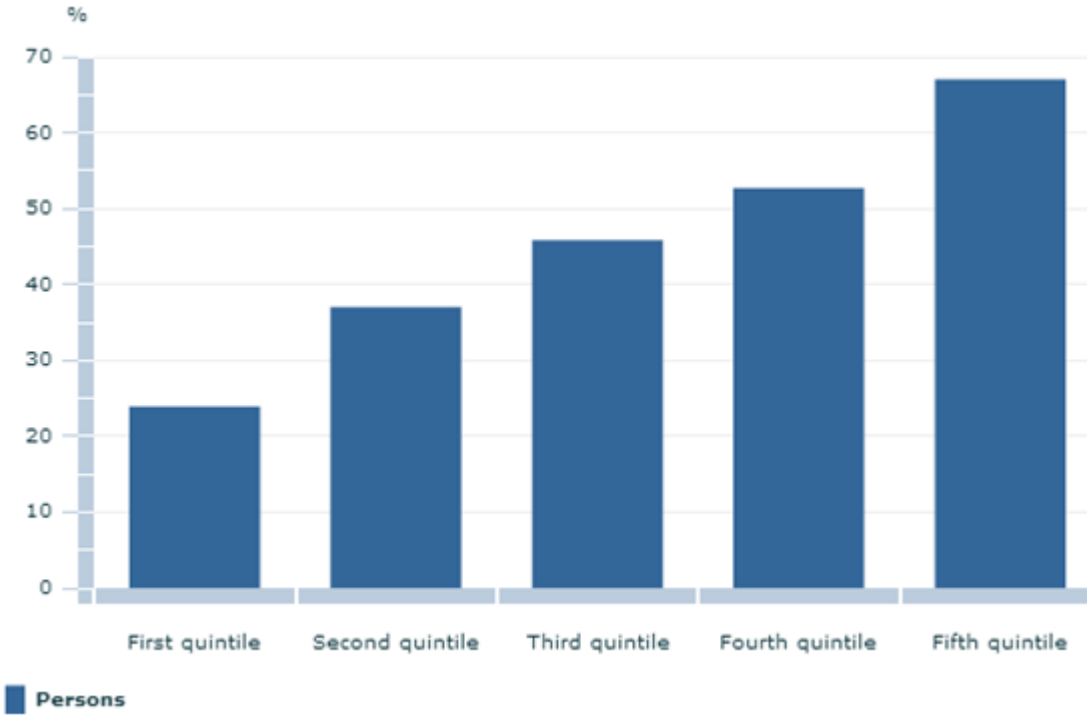
Transport costs associated with accessing healthcare are not included in the standard compilations of out-of-pocket costs. This is an important consideration for people in more remote areas for whom travel to any more specialised care is regularly required. Travel and accommodation costs associated with healthcare contribute much more to a *rural* household's total health care costs than for households in the major cities. The cost of flights soon adds up and are not covered under private health insurance arrangements.

Further developments of telehealth should help reduce this need to travel and additional investments in information and funding for patients' accommodation and travel schemes is also urgently needed.

Reducing or avoiding high out-of-pocket costs

Some of the out-of-pocket costs of health care can be covered by taking out private health insurance. However this is yet another area where the people of rural and remote areas are disadvantaged. The rate of private health insurance (PHI) coverage decreases with remoteness (see Figure 3 below).

Figure 3: Proportion of persons aged 15 years and over, with private health insurance, hospital and extras cover in previous 12 months



[25] *Media Release: One in five people delayed or did not go to a dentist due to cost* (2013), ABS, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4839.0Media%20Release12012-13?opendocument&tabname=Summary&prodno=4839.0&issue=2012-13&num=&view=

The AIHW reports that 57 per cent of people in Major cities have private health insurance, compared with 48 per cent in Inner regional areas and 41 per cent in Outer regional areas. The ABS reports that people in Major cities were more likely to have hospitals and extras cover than those living in Outer regional, Remote or Very remote areas of Australia (48.6 per cent compared with 40.6 per cent).[26]

There are two principal reasons for the urban-rural membership differences: affordability and choice. First, income is one of the strongest predictors of PHI uptake, and average incomes are lower in regional than in urban areas. Multiple studies show a clear income gradient to the uptake of PHI, with lower income groups less likely to have PHI.

Second, PHI membership is less attractive to residents of regional areas because of the limited availability of private facilities. The central reason to purchase PHI cover is to have affordable access to private hospital facilities. ABS and AIHW statistics on hospitals and bed numbers by location indicate that private facilities are concentrated in urban areas.

Another means by which out-of-pocket health care costs can be reduced for country people is by giving them access to patient assisted accommodation and travel schemes. Each state has its own patient assisted travel schemes which partially subsidise these expenses, but it is the Alliance's longstanding view that these schemes are poorly promoted, imperfectly understood and insufficiently funded. The support available certainly does not reflect the real costs of having to travel to large centres for care and being away from one's own work and community.

A third way in which out-of-pocket costs can be minimised is through the existence of safety nets such as exist for Medicare and the PBS**.** The Alliance is concerned about the current proposal to increase to $2000 the threshold for the Medicare safety net for those who do not have a health care card.

A major concern of the proposed threshold change is that it will deter or prevent people from accessing much-needed medical services. Alliance research shows that various groups in rural communities, such as men and young people, are often reluctant to seek medical assistance. It is important that this situation is not exacerbated, especially given the critical preventive role that medical professionals have in overseeing and managing patients' health conditions, before they become more serious.

Medication safety net thresholds should also not be increased as higher medication costs will result in less appropriate medication use and higher costs related to avoidable hospitalisations. Employment of more salaried pharmacists in hospitals, community health, palliative care, mental health and aged care would result in less medicated related hospitalisations and slower progression of chronic disease in rural and remote areas, especially in areas where it is not viable to have a community pharmacy or in areas of GP shortage.

Recommendations

1. The adequacy of patient assisted travel schemes needs to be reviewed. Among the considerations would be whether subsidy levels have kept pace with rising fuel, public transport and accommodation prices; and the apparently worsening situation

[26] *4839.0 - Patient Experiences in Australia: Summary of Findings, 2012-13* (2013), ABS, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4839.0main+features62012-13

with respect to affordable accommodation close to the more specialised health services in the major cities that people from more remote areas need to attend.

2. The necessary costs of travel and accommodation away from home to access health services should be factored in to published figures about standard out-of-pocket health care costs. Ongoing measurement of such unavoidable costs would help to ensure public accountability for travel and accommodation subsidy levels.

3. There needs to be continued collaborative work to extend the adoption in rural and remote areas of various services which fall under the general heading of 'telehealth'. The work needs to involve all levels of government, service providers and clinicians and consumers living in rural and remote areas. Consideration needs to be given to issues relating to connectivity for both fixed and mobile telephony and the integration of current and yet-to-be-deployed systems. The work would result in the identification of barriers to the development and take-up of existing and potential service models, and cost-effective facilitators which would include ongoing support and training for those who will be using such systems.

4. Depending on the decisions made in the 2014 Federal Budget it may be necessary to closely monitor the differential impact of Medicare copayments on people in rural and remote areas. There should be close study of the effects of such additional payments across remoteness and SEIFA gradients, particularly effects such as skipped or delayed visits to GPs and other clinicians, and potentially preventable hospitalisations.

Conclusion

Average out-of-pocket costs *per service* for non-referred Medicare services are 10 per cent higher for people in regional areas than in the Major cities, 20 per cent higher for people in Remote areas, but lower for people in Very remote areas (see Table 4).

Out-of-pocket *hospital* costs are lower for regional people, largely because they cannot afford or choose not to buy private hospital cover. However people in remote areas are heavier users of public hospitals than those in the Major cities.

The standard and measured out-of-pocket costs do not include travel costs involved in accessing health care away from home. Furthermore, the impact of a given level of out-of-pocket health care costs is greater for low income families and such families are more prevalent in rural and remote areas. These are also more likely to be in need of health services than better-off families.

Rates of bulk billing by health professionals are slightly lower in regional and Remote areas than the cities, but higher in Very remote areas. The average out-of-pocket costs to those who are not bulk billed is $29.94 in Major cities compared with $32.59 in Remote areas and $33.82 in Very remote areas.

These are all serious issues given the situation in which people in rural and remote areas already experience an overall health care deficit of $2.1 billion a year.

If Australia's universal healthcare system is to work fairly, it must include the means to ensure that out-of-pocket costs do not work to limit people's ability to access primary care.

The best hopes for this are through greater support for those health professionals already in rural and remote areas, achieving a better national distribution of the health workforce,

boosting patient travel and accommodation schemes, and through the MBS and PBS safety nets.

Delivering health services to rural and remote Australia is bound to cost more. There are ongoing challenges but also wonderful success stories. To enable first world health standards, out-of-pocket costs must not be borne disproportionately by people living in rural and remote communities.

Attachment

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Committee)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)