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**Estimated impact of proposed GP, pathology and imaging co-payments for Medicare services, and the increased PBS threshold
Additional cost burden to patients from budget co-payment proposals: BEACH data**

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Snapshot

Estimated impact of proposed GP, pathology and imaging co-payments for Medicare services, and the increased PBS threshold

Additional cost burden to patients from budget co-payment proposals: BEACH data

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In the May 2014 Budget, the Federal Government proposed

- introducing a \$7 co-payment for selected general practice (GP) services, out-of-hospital pathology testing, and imaging services bulk-billed through Medicare
- increasing the patient co-payment for prescribed medications subsidised by the Pharmaceutical Benefits Scheme (PBS).

Using 2013-14 BEACH data, we estimated the additional out-of-pocket cost to general practice patients resulting from: the \$7 co-payments for general practice, pathology and imaging Medicare services; the increase in the PBS co-payment; and the combination of both these policies.

Effect of GP, pathology and imaging co-payments

We found that:

- over a quarter of adult GP consultations involved at least one test (minimum out-of-pocket cost for the consultation is \$14 in co-payments),
- about 3% of adult GP consultations involved imaging **and** pathology tests (minimum co-payment = 3 x \$7 = \$21)

Average annual additional cost due to the patient co-payments increased with patient age:

- *from* about \$35 per year per child
- *to* about \$94 per year per person for patients aged 65 years and over.

Effect of increased co-payments for medications

Though the cost increase is 80 cents per medication for concessional patients compared with \$5 for general patients, the actual cost increase for medications will be higher for concessional patients.

Effect of both policies together

If both policies were introduced the **average** annual additional cost to a patient increases with age from \$36 for children to \$122 for patients aged 65 years or more.

We have been conservative in our estimates, and have not considered:

- additional costs resulting from plans for decreased Medicare rebates for pathology and imaging items claimed from Medicare by general patients not bulk-billed for these services.
- additional costs for GP consultations, pathology and imaging test orders if individual health providers choose not to bulk bill. If privately billed, the out-of-pocket cost for the patient is likely to be more than \$7 per service.

International evidence overwhelmingly suggests that the most efficient, effective and equitable health systems have a strong primary care focus. We have shown that these policies will create a larger price signal than previously suggested in the media. This cost can be quite significant, especially for patients aged 65+ years or for those who have one (or multiple) chronic condition(s) requiring regular management.

Examples of the impact of co-payments

- **A young family of four** with two children (aged <16 years) and two parents aged 25-44 years would expect to pay an average of:
\$170 in co-payments for GP visits and tests + \$14 for medications = **\$184 more per year**.
- **A self-funded retired couple** aged 65 years or more (without Commonwealth concession cards) would expect to pay an average of:
\$189 in co-payments for GP visits and tests + \$55 for medications = **\$244 more per year**.
- **An older couple who are pensioners** (aged 65 years or more, with concession cards) would expect to pay an average of:
\$140 in co-payments for GP visits and tests + \$59 for medications = **\$199 more per year**.

The impact on a general practice patient with **Type 2 diabetes**

- An average general patient at a consultation who has Type 2 diabetes would **pay an extra \$120 per year** in co-payments for GP visits and tests, and 25% of these patients would spend \$150 or more per year on these co-payments.
- For the average patient with Type 2 diabetes and a concession card, the cost of co-payments for GP visits and tests would be capped at \$70.

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Estimated impact of proposed GP, pathology and imaging co-payments for Medicare services, and the increased PBS threshold

Additional cost burden to patients from budget co-payment proposals: BEACH data

Background

In May 2014, the Federal Government proposed a number of substantial changes to the health budget. These included: introduction of a \$7 co-payment for selected general practice services and for out-of-hospital pathology and imaging services, funded through the Medicare Benefits Schedule (MBS); and increased co-payments for medications on the Pharmaceutical Benefits Scheme (PBS).¹ These policies refer to three different groups of patients: children (aged less than 16 years); concessional patients (Commonwealth concession card holders); and general patients (all other patients).

This Byte investigates the additional out-of-pocket cost to general practice patients resulting from: the \$7 co-payments for general practice, pathology and imaging MBS services; the increase in the PBS co-payment; and the combination of both these proposals. We use recent data from the BEACH (Bettering the Evaluation and Care of Health) program. BEACH is a continuous national study of general practice activity, in which annual ever-changing randomly sampled general practitioners (GPs) each records details of 100 GP-patient encounters.

The proposed change to Medicare rebates

The Government is proposing to reduce the Medicare rebate from July 2015 by \$5 for selected general practice, pathology services and imaging services.¹ The bulk-billing incentive is also to be removed for general patients for pathology and imaging services.^{2,3}

Patients using these services are currently either bulk-billed or privately billed. Bulk-billed patients have no out-of-pocket expenses, with the health care provider receiving the MBS rebate set by the Government, directly from Medicare. In contrast, privately billed patients pay directly for their services at the fee set by the provider, and claim the eligible MBS rebate from Medicare.

The budget proposal is for patients who are currently being bulk-billed by their GP(s), to be charged a \$7 co-payment for each standard GP consultation service, each out-of-hospital pathology episode of service, and for each out-of-hospital imaging service. For children and for concessional patients, the proposed co-payment will be capped at \$70 per calendar year (or co-payment for 10 services in any combination of GP, pathology or imaging services). It is intended that \$5 of the \$7 will cover the reduction in the Medicare rebate mentioned earlier, with the remaining \$2 going to the provider. Privately billed patients would receive \$5 less when they claim the Medicare rebate for each relevant service.¹

Levels of bulk-billing are currently high for the targeted GP, pathology and imaging services. In 2012-13, 82.2% of GP attendances, 87.2% of pathology, and 74.8% of diagnostic imaging services were bulk-billed.⁴ It could be argued that historically, maintaining high bulk-billing rates has been an objective of health policy. For example, to encourage bulk-billing, the Government pays 'bulk-billing incentives' for all bulk-billed out-of-hospital pathology and imaging services, and for general practice

services in selected circumstances (e.g. patients aged <16 years; concession card holders; in rural areas).

Under the proposed changes, the bulk-billing incentives will be replaced with ‘Low Gap Incentives’, payable only when the \$7 is collected.¹ For general practice services, the Low Gap Incentives will be available for the same groups of patients for whom the bulk-billing incentives were available. However, for pathology and imaging providers they will only apply to services provided to children and concessional patients, instead of all bulk-billed patients.^{2,3}

Providers of these services (GPs, pathologists and radiologists) have the choice of whether or not to charge the co-payment. If they choose not to, they will receive the lower Medicare rebate, and forfeit any applicable Low Gap Incentive. For children and concessional patients, \$7 is the fixed amount (i.e. the maximum and minimum) that must be charged if the provider wants to collect the Low Gap Incentive.¹

We know that different members of our community use health services at different rates. For example the **average** number of GP visits made by the Australian population who visited a GP at least once in 2012-13 was 6.6 times per person.⁵ However, it increases substantially with age from an **average** of 4.5 visits for children to 10.5 for those aged 65 years and over. A similar age-related pattern is found in the use of pathology services.⁶ Therefore, the introduction of co-payments will not have an equal impact across the population.

- It is the high users, usually the older, sicker people in our community who will be most affected. The likely impact on these vulnerable groups has caused concern for a number of professional bodies including the Australian Medical Association (AMA), Royal Australian College of General Practitioners (RACGP), and Australian Diagnostic Imaging Association (ADIA).^{3,7,8}
- There is sufficient evidence that the introduction of a co-payment will change patterns of health service use, and that there will be different impacts for different patient groups.⁹
- Compared with other OECD countries, Australia already has one of the highest levels of out-of-pocket health costs.¹⁰ Through introduction of the co-payments the Government aims to “ensure health services are sustainable and used efficiently”.¹ However there is no evidence that any modelling was performed to assess the effect of co-payments on deterring people from seeing a GP, or the flow-on effect on hospital emergency department attendances.^{11,12}
- In 2012-13, 5.8% of people delayed or did not see a GP due to cost, and this was a greater barrier for people from more disadvantaged areas.^{13,14} The Healthy Communities report showed that cost as a reason for delaying or not seeking GP care varies by communities in Medicare Locals areas, ranging from 1% to 13%.¹⁵ With the introduction of co-payments health groups expect a rise in those delaying or not seeking care.^{7,8}

The first aim of this paper is to estimate the **average** out-of-pocket expenses for management provided or ordered in general practice for patients who are currently bulk-billed. We focus exclusively on patients who are bulk-billed, as they currently do not face a price signal. Patients who are currently privately billed already face a price signal larger than \$7 per consultation on **average**.

Objective 1: To assess the size of the price signal that co-payments will generate for general practice patients who are currently bulk-billed.

The proposed increase to PBS medication co-payment

Medications in Australia are subsidised through the PBS. Patient co-payments for medications have been a long standing policy, having been applied in various forms since 1960.¹¹ At present (May 2014), general patients pay a maximum of \$36.90 for PBS medications, and concessional patients pay a maximum of \$6.00. This maximum co-payment (referred to as the threshold) is indexed to CPI on 1st January each year.

The second budget proposal is that patient's co-payments for medications funded through the PBS will increase from January 2015 by \$5 for general patients and children and by 80 cents for concession card holders.¹ Incorporating the inflation estimates for January 2015, general patients will pay \$42.70 and concession card holders will pay \$6.90.¹ This co-payment only applies to medications that cost more than the co-payment amount—medications that cost less than the co-payment threshold will not be affected. Currently 40% of medications on the PBS fall below the co-payment threshold. If this budget proposal is implemented the Government expects this proportion to increase to 55%.¹¹

However, there is concern that any increase in costs incurred by the patient for medications will lead to more patients not filling their necessary prescriptions. In 2012–13, 8.5% of people reported that cost was a barrier to filling a prescription.¹⁴ This was higher for Indigenous patients and for patients in the most socio-economic disadvantaged areas.^{13,16} The recent Healthy Communities report shows that this varies by community with a range of 5% to 15% of patients in Medicare Local areas reporting that they had delayed or not filled a script because of cost.¹⁵

Objective 2: To assess the additional cost patients will face from the increase in the PBS threshold

Our second aim is to estimate the **average** additional out-of-pocket expense for prescribed medications, due to the proposed increased PBS threshold for both general patients and concessional patients.

Objective 3: To assess the additional cost patients will face from both proposals combined

The budget papers give examples of the impact on patients of the rise in the PBS threshold, and the impact of the \$7 co-payment for GP consultations on families and individuals. However, these examples do not incorporate the combined effect of the additional co-payments required for GP consultations, pathology, imaging and medications. It is the compounded effect of the co-payments that has raised the concern of many health organisations, particularly as they will have a greater impact on some groups in the community, than others.

The third aim is therefore to estimate the combined additional cost to patients of both these proposals.

Methods

We used the data from the latest BEACH year, April 2013-March 2014. We divided patients into logical age groups: 0-15 years (those who have a cap of 10 co-payments per year); 16-24; 25-44; 45-64; and 65 years or older. We included consultations where the GPs reported that the service was to be claimed as a Medicare Benefits Schedule item. We excluded encounters that were paid for by the patient, the Department of Veterans' Affairs, other bodies (e.g. workers compensation,

state/territory health departments) and those encounters where the GP indicated that no fee was charged.

Estimating the cost of the co-payments for GP services, pathology and imaging tests

We measured the age-group-specific proportion of consultations where:

- at least one pathology test was ordered
- at least one imaging test was ordered
- no tests were ordered
- at least one test type was ordered (i.e. pathology AND/OR imaging)
- one test type was ordered (i.e. pathology OR imaging)
- two test types were ordered (i.e. both pathology AND imaging)

We calculated the **average** additional cost per consultation for pathology tests, and for imaging tests, by multiplying the proportion of consultations at which these tests were ordered by \$7. Both these additional costs were added together with the \$7 GP consultation co-payment to estimate the **average** additional patient cost per consultation.

The **average** number of consultations with patients was calculated for each age-group by dividing the total number of Medicare items claimed for that age group by the total number of people in that age group who claimed at least one Medicare item that year. The data were for the previous BEACH year (April 2012-March 2013) and were supplied by the Australian Government Department of Health (personal communication, June 2013).

An additional analysis examining patients with Type 2 diabetes was performed. We used results from a BEACH prevalence sub-study in which the GP was asked whether the patient had any chronic conditions. Type 2 diabetes was a tick box option. This allowed us to identify what happens at consultations with patients with Type 2 diabetes, even when Type 2 diabetes is not managed at consultation. We used the consultation data for patients who were identified in the sub-study as having Type 2 diabetes, to assess the proportion of their consultations that involved a pathology or imaging test order.

To determine the number of times patients with Type 2 diabetes attended general practice over the year, we used data from another sub-study specifically examining the resource use of patients with Type 2 diabetes. In this sub-study the GP was asked to record the number of times the patient had seen any GP in the past 12 months.

Estimating the additional out-of-pocket expense to patients due to the PBS threshold increase

We included medications that were prescribed to patients. We excluded medications that were unlikely to be provided on the PBS, such as immunisations provided through the National Immunisation Program free of charge; and travel vaccines paid for privately. We excluded medications that the GPs indicated were supplied directly to the patient, and those advised for over-the-counter purchase by the patient.

We included any repeats written for the medication. We took a conservative approach, assuming that if the GP left the number of repeats box empty, there were no repeats.

We mapped medications in the Pharmaceutical Benefits Scheme (May 2014) to the medication coding system used in the BEACH program. We counted the number of scripts for which the full increase would be passed on to the patient, that is, for general patients those medications currently costing \$42.70 or more and for concession card holders, \$6.90 or more. We then calculated the **average** additional cost of medications per consultation.

Results

Co-payments for GP services, pathology and imaging tests

More than one-quarter of GP consultations with adult patients (aged 16+ years) involved at least one order for imaging or pathology (leading to total cost for the consultation of at least \$14), and about 3% of consultations with adults involved both an imaging and pathology test, resulting in at least an additional \$21 in costs in co-payments (Table 1).

Children aged <16 years had the least chance out of all the age-groups of having either a pathology test (7.4% of consultations) or an imaging test (4.6% of consultations) (Table 2). The additional cost of co-payments per consultation for a child **averaged** \$7.84 per consultation.

The proportion of consultations with adults that involved at least one pathology test was fairly similar across all age-groups, with about one-in-five consultations involving at least one test. It was a similar story for imaging, with about one in ten consultations involving imaging test(s). Due to the similarity in test ordering at adult consultations, the additional cost to adults due to co-payments for the GP visit and for tests was similar – around \$9 per GP consultation.

On **average**, the number of GP consultations patients had in a year increased significantly with age, from 4.5 visits for children to 10.5 visits for patients aged 65 years or over. This meant that on **average** the total additional annual cost to patients due to the co-payment increased with patient age from about \$35 per year for children to about \$94 per year for patients aged 65 years and over. For concessional patients and children, the cost of co-payments would be capped at \$70.

Examples

- A family with two young children (aged <16 years) and two parents (aged 25-44 years) would expect to pay an additional \$170 in co-payments per year on **average**.
- A self-funded retired couple (both aged 65+, no concession cards) would expect to pay an additional \$189 per year in co-payments on **average**.
- An older couple who are pensioners (aged 65 years or more, with concession cards) would expect to pay an additional \$140 per year in co-payments on **average**.

Type 2 diabetes: example of impact on patients with chronic disease

The above results are based on the '**average**' patient. There is wide variability in the number of times patients attend general practice. An example of someone who attends more often is a patient who has Type 2 diabetes. Our analysis of general patients at consultations, who have Type 2 diabetes shows that they receive a pathology test at about 20% of their consultations and an imaging test at about 9% (Table 3). Overall, the **average** additional cost for a patient with Type 2

diabetes is \$9 per consultation. This is similar to the cost for an **average** adult patient. However, we know that patients with Type 2 diabetes visit the GP far more than average – these patients reported seeing a GP 13.5 times in the previous 12 months. They would therefore have on **average** an extra \$120 in costs from co-payments over the year. One-quarter of Type 2 diabetes patients attended 16.5 times or more (17+ times in reality) adding at least \$148.50 in additional co-payment charges in the year.

Increase in out-of-pocket expenses due to increases in PBS co-payments

The **average** number of prescribed medications above the proposed PBS price threshold at GP consultations increased with patient age, from 0.05 per consultation for children to 0.53 per consultation for patients aged 65 or more (Table 4). These represented about 12% of all the medications (including those advised for over-the-counter purchase and those supplied by the GP). For general patients the **average** additional cost of **medications** per year would range from \$1.15 for children to \$27.77 in adults aged 65 or older.

Due to the lower PBS threshold, concessional patients have far more medications prescribed that will incur the full co-payment increase, ranging from an **average** 0.87 medication per consultation with children to 3.54 medications per consultation for older patients (Table 5). Even though the cost increase is only 80 cents per dispensed medication for concessional patients compared with \$5 for general patients, the actual collective increase in costs for medications will be greater for concessional patients. For concessional patients the **average** additional cost of **medications** per year would range from \$3.11 for children to \$29.65 in adults aged 65 or older.

Increase in out-of-pocket expenses due to introduction of both proposals

Table 6 shows the **average** extra costs to general patients if the Medicare and PBS budget proposals were introduced in their current form. The **average** annual additional cost increases with age from \$36.27 for children to \$122.17 for patients aged 65+.

Overall, there is little difference in the **average** additional amount that general and concessional patients would have to pay over a year (Table 7). The only real difference would be among patients aged 65 years or more — as concessional patients would have their co-payments for services capped at \$70, while general patients would not.

Examples of the combined effect

- A family with two young children (aged <16 years) and two parents (aged 25-44 years) would on **average** have to pay an additional \$184 per year (\$169.92 for GP, pathology and imaging + \$13.62 for medications).
- A self-funded retired couple (both aged 65+, no concession cards) would expect to pay an additional \$244 per year on **average** (\$188.80 for GP, pathology and imaging + \$55.54 for medications).
- An older couple who are pensioners (aged 65 years or more, with concession cards) would expect to pay an **average** additional \$199 per year (\$140.00 for GP, pathology and imaging + \$59.30 for medications).

Table 1: Proportion of GP consultations at which one, two or at least one, pathology and/or imaging test was ordered, by patient age group

Patient age group	No test ordered (% of consultations) (Minimum additional \$7)	At least one imaging or pathology test was ordered (% of consultations) (Minimum additional \$14)	One test type ordered (% of consultations) (Minimum additional \$14)	Two test types ordered (% of consultations) (Minimum additional \$21)
Aged 0-15 years	88.76%	11.24%	10.52%	0.72%
Aged 16-24 years	73.35%	26.65%	23.66%	2.99%
Aged 25-44 years	70.31%	29.69%	26.29%	3.40%
Aged 45-64 years	69.48%	30.52%	27.06%	3.46%
Aged 65+ years	73.85%	26.15%	23.62%	2.53%

Table 2: Proportion of GP consultations at which pathology or imaging test(s) were ordered and expected average additional direct costs to patients each year, by patient age-group.

Patient age group	Proportion of consultations where a pathology test was ordered	Average additional cost for pathology per consultation	Proportion of consultations where an imaging test was ordered	Average additional cost for imaging per consultation	Average additional direct costs per consultation	Average number of consultations of patients in 2012-13	Average additional direct cost per year
Aged 0-15 years	7.38%	\$0.52	4.58%	\$0.32	\$7.84	4.48	\$35.12
Aged 16-24 years	20.49%	\$1.43	9.15%	\$0.64	\$9.07	4.73	\$42.94
Aged 25-44 years	22.27%	\$1.56	10.83%	\$0.76	\$9.32	5.35	\$49.84
Aged 45-64 years	22.96%	\$1.61	11.02%	\$0.77	\$9.38	6.30	\$59.12
Aged 65+ years	19.63%	\$1.37	9.04%	\$0.63	\$9.01	10.48	\$94.40

Table 3: Proportion of GP consultations with patients with Type 2 diabetes where a pathology or imaging test was ordered and expected average additional direct costs to patients each year

Type 2 diabetes (T2D) patients at GP consultations	Proportion of consultations where a pathology test was ordered	Average additional cost for pathology per consultation	Proportion of consultations where an imaging test was ordered	Average additional cost for imaging per consultation	Proportion where no test was ordered	Average additional direct costs per consultation	Average number of consultations by patients with T2D	Average additional direct cost per year
Average T2D patient	19.88%	\$1.39	8.68%	\$0.61	74.25%	\$9.00	13.5	\$121.49
Bottom Quartile patient	19.88%	\$1.39	8.68%	\$0.61	74.25%	\$9.00	7.0	\$63.00
Upper Quartile patient	19.88%	\$1.39	8.68%	\$0.61	74.25%	\$9.00	16.5	\$148.50

Table 4: The number of medications over the PBS threshold prescribed to children and general patients at consultations, additional cost in medications per consultation and total average additional cost per year, by patient age group

Patient age group	Average number of threshold medications prescribed at consultation	Additional cost per consultation for medications	Average number of patient consultations in 2012-13	Average additional cost of medications per year
Aged 0-15 years	0.05	\$0.26	4.48	\$1.15
Aged 16-24 years	0.12	\$0.59	4.73	\$2.77
Aged 25-44 years	0.21	\$1.06	5.35	\$5.66
Aged 45-64 years	0.41	\$2.06	6.30	\$12.99
Aged 65+ years	0.53	\$2.65	10.48	\$27.77

Table 5: The number of medications over the PBS threshold prescribed to concessional patients at consultations, additional cost in medications per consultation and total average additional cost per year

Patient age group	Average number of threshold medications prescribed at consultation	Additional cost per consultation for medications	Average number of consultations for patients in 2012-13	Average additional cost of medications per year
Aged 0-15 years	0.87	\$0.69	4.48	\$3.11
Aged 16-24 years	1.28	\$1.02	4.73	\$4.84
Aged 25-44 years	1.95	\$1.56	5.35	\$8.36
Aged 45-64 years	3.29	\$2.63	6.30	\$16.59
Aged 65+ years	3.54	\$2.83	10.48	\$29.65

Table 6: Estimated increased cost of general practice care over a year for a child or general patient

Patient age group	Average additional cost of direct care per year	Average additional cost of medications per year	Average additional total cost for general practice care
Aged 0-15 years	\$35.12	\$1.15	\$36.27
Aged 16-24 years	\$42.94	\$2.77	\$45.71
Aged 25-44 years	\$49.84	\$5.66	\$55.50
Aged 45-64 years	\$59.12	\$12.99	\$72.11
Aged 65+ years	\$94.40	\$27.77	\$122.17

Table 7: Estimated increased cost of general practice care over a year for a concessional patient

Patient age group	Average additional cost of direct care per year	Average additional cost of medications per year	Average additional total cost for general practice care
Aged 0-15 years	\$35.12	\$3.11	\$38.23
Aged 16-24 years	\$42.94	\$4.84	\$47.78
Aged 25-44 years	\$49.84	\$8.36	\$58.20
Aged 45-64 years	\$59.12	\$16.59	\$75.71
Aged 65+ years	\$70.00	\$29.65	\$99.65

Discussion

Using Australia's best source of general practice data, we have shown that many GP consultations will incur a co-payment greater than \$7. We have also shown that the cumulative effect of the co-payments will be greater than \$70 for the **average** general patient aged 65+ and the **average** general patient (no matter what age) with Type 2 diabetes. The PBS increase, while only 80 cents for concessional patients compared with \$5 for general patients, represents a greater increase for concessional patients, due to the number of medications which will be affected. We wish to stress to the reader that we have made every possible effort to be conservative in our estimates of these out-of-pocket expense increases.

Following is a list of ways that we may have underestimated the increase in costs that will eventuate from co-payments.

- 1) Our calculations are based on the introduction of \$7 co-payments. We haven't considered the possible impact of providers choosing to charge higher co-payments. Under the current proposal, there will be no incentive for providers to only charge \$7 co-payments for general patients. Given the costs involved in installing/setting up a billing system (e.g. eftpos, cash-handling systems) to charge the co-payment in practices who only bulk-billed previously, many providers may choose to charge general patients privately—Therefore, allowing them to charge more than \$7 to recoup their expenses.

The loss of bulk-billing incentives for imaging and pathology services for general patients means that in order for these providers to retain the same income, patients would have to be charged more than \$7. This can be a substantial amount of money in some cases. For example, for imaging services, the loss of the current bulk-billing incentive can represent a loss of \$4.72 for a chest x-ray, \$29.50 for a chest CT and \$60.48 for a head MRI.³ For pathology services, the current incentives range from \$1.40 to \$3.40 (most frequently \$3.40) per episode.² While the imaging bulk-billing incentives are higher, there are far more episodes of pathology services.

Professional bodies have suggested that the proposed co-payment will encourage providers who previously bulk-billed to switch to private billing.^{2,3,7} It is hard to estimate how much extra they would charge their patients, though it is likely to be more than the proposed \$7 co-payment for each service. In 2012-13, when charged, the **average** patient contribution was \$29.32 for GP attendances, \$22.91 for pathology, and \$88.02 for imaging services.⁴ If providers switch to private billing and charge these **average** gaps, these changes would at least triple our estimates for general patients.

- 2) In our calculations we only counted imaging and pathology generated by GP management of patients attending general practice. Out-of-hospital imaging and pathology services can be ordered by other medical specialists and the budget proposal indicates that co-payments would be applicable for these services. For example we know that GPs generate 70% of pathology services, with the remainder being ordered by other medical specialists.¹⁷ It is reasonable to assume that patients who are sicker, and those with chronic disease are more likely to be under the management of other medical specialists and also have co-payments arising from pathology and imaging investigations ordered by these clinicians. We have likely produced an underestimation as we have not counted the additional cost of other out-of-hospital pathology and imaging services ordered by non-GP medical specialists.

- 3) In terms of the PBS threshold increases, we only counted medications for which the full increase would apply. There were some medications for which only a partial increase would apply. We also assumed that a missing response in the ' number of repeats' section for a medication meant zero repeats. This may have resulted in an underestimate of the total number of medications that will be purchased through the PBS over the year.
- 4) For imaging tests, we only measured whether a test was ordered at the consultation (thus only counting one co-payment). However, each imaging test that generates a Medicare item number will create a co-payment. This is different from GP consultations and pathology services where the co-payment will apply once per episode of service. Tests ordered at some consultations would generate more than one imaging item number, and therefore incur two or more co-payments. We only counted one co-payment for one or more imaging tests ordered, thus underestimating the additional cost to the patient.
- 5) Most importantly, we have used **averages** for each patient age group. We acknowledge that there are healthier and sicker individuals within each age group, with different needs for health services. However, we know that people who are of limited means are the most likely to have poorer health.¹⁸ It is likely that these co-payments will most affect those least able to afford them.

Some other issues that may affect our estimates are discussed below.

- We used data from consultations that GPs recorded as Medicare-claimable. The Government indicated that co-payments would “not be expected” for some “GP services that target patients with particular health needs”.¹ We do not know what services will be exempt. We may have included some consultations that will be exempt, such as the GP Chronic Disease management items. These items account for less than 5% of Medicare-claimable general practice consultations, and it is unclear whether the co-payments for pathology and imaging services generated at these exempt general practice consultations will apply. Therefore we believe that the inclusion of these consultations is unlikely to affect the **average** estimates made in this report.
- In calculating the estimated average additional cost of PBS medications, we used the current (May 2014) PBS cost of medications, and the forecast co-payment threshold at January 2015 (incorporating the proposed increase + inflation estimates). We do not know if the PBS price of medications or the forecast PBS threshold will change. Such changes would affect our estimates.
- We also modelled our results on patients who are currently bulk-billed. This is because the purpose of co-payments is to provide a price signal to “consumers”, whereas privately billed patients already face a price signal.

GPs, pathologists and radiologists will not be forced to charge the \$7 co-payment to concessional patients. However, if the provider does not charge a co-payment they will lose more than the rebate reduction (\$5), as they also lose the applicable Low Gap Incentive. For example, for a standard GP consultation this represents a total loss of \$11 (or more in rural areas). This suggests it would not be financially viable to regularly waive the co-payment.

Through the introduction of the co-payments on general practice services, the Government states that they will “ensure health services are sustainable and used efficiently”.¹ It would be remiss of us as general practice researchers if we did not point out that discouraging people from using primary

care health services flies in the face of all international evidence. As Barbara Starfield said “*the literature on the benefits of primary care oriented health systems was consistent in showing greater effectiveness, greater efficiency, and greater equity*”.¹⁹

It is likely that the increased costs due to these policies would deter more people from seeking early treatment or from taking necessary medications.⁹ This is a concern when areas in Australia already have 13% of their population delaying or not seeing a GP due to cost, and 15% doing the same for prescriptions.¹⁵ Overseas studies have shown that there is little evidence of health care cost reduction from introducing co-payments. The evidence suggests that long-term health costs will be higher due to patients deferring necessary care, resulting in increased hospitalisation and progression of disease.⁹ International evidence overwhelmingly suggests that the most efficient, effective and equitable health systems have a strong primary care focus.¹⁹ We believe that if Australia is to maintain an efficient and equitable health care system, general practice requires investment, not reductions.

Conclusions

We have shown that even with our conservative estimates, these proposed policies will create a larger price signal than that suggested in the media to date. Many GP consultations will generate more than one \$7 co-payment, with an **average** one-quarter of consultations with adult patients (aged 16+ years) resulting in at least \$14 in co-payments. The combined annual effect of the GP, testing and medication co-payments is significant. A general patient with Type 2 diabetes (no matter what age) will pay an **average** additional \$121.49 toward their care annually. General and concessional patients aged 65+ years will pay comparable amounts: general patients will pay an **average** \$122.17 per year, and concessional patients an **average** of \$99.65. This is because the PBS increase, while only 80 cents for concessional patients compared with \$5 for general patients, represents a greater increase for concessional patients, due to the number of medications that will be affected. This work demonstrates the significant cumulative costs of the budget proposals, particularly for patients aged 65+ years or for those who have one (or multiple) chronic condition(s) that require(s) regular management.

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