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Adoption of out-of-pocket cost caps: an Australian perspective

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Out-of-pocket (OOP) costs are on the rise worldwide, prompting many countries to cap health consumer's co-payments, as part of their efforts to enhance healthcare access and equity. The recent Inflation Reduction Act 2022 (USA) mandated capping of patient payments for many high value preventive services.[1] We reflect on the applications of OOP cost caps in the Australian context, and the ramifications of increased financial pressures for people on lower incomes and a lack of optimal price awareness among health consumers driving up healthcare costs.

Health services in Australia are provided through a blend of public and private providers, with government subsidises. Even with universal health insurance via Medicare, consumers pay ~17% of total health expenditure directly to providers in OOP payments.[2] OOP cost caps, termed SafetyNets, reimburse Australian consumers at a higher amount once they reach a certain threshold of gap payment for out-of-hospital services or pay 80% of further OOP costs in a year. Thresholds for OOP caps are lower for concession holders (A$770.30 vs A$2414.00).

Despite having these measures for more than two decades, OOP costs have continued to grow and disproportionally burden the chronically ill (e.g. older adults) and disadvantaged populations. SafetyNets do not directly support healthcare accessibility for people who are unable to pay market prices as people are required to cover the expenses upfront and then seek government reimbursement. Economically disadvantaged individuals lack financial means to afford services (e.g. general practitioners), now that the full-service coverage (i.e. bulk-billing) is no longer the norm and providers are able to set their own fees. Many Australians do not hit the non-concession-card threshold each year and forego healthcare because of the high initial cost.

Having private health insurance offers no assurance of complete coverage, with 56% of private patients still paying OOP costs to providers.[3] Additionally, government subsidisation of private health insurance premiums causes substantial transfer of public health expenditure in the form of private health insurance and private care subsidies to more affluent health consumers since they have the financial capacity to pay private health insurance premiums.[3] Inflationary healthcare prices have also become a challenge. SafetyNets have been shown to make consumers less sensitive to the fees charged by providers, enabling providers to raise their fees without the potential for reduced demand for services.[4]

An income-based OOP cost payment approach specifically tailored to benefit people with lower income may be a suitable policy alternative. This approach could consequently reduce price inflation, as economically advantaged consumers will start shopping for value. Income-driven co-payment rates have been implemented in Japan to limited extent and have been shown to mitigate income disparities.[5] Equitable OOP cost caps has the potential to be effective in reducing the unfair financial burden on the lower income communities and ultimately enhancing healthcare access and equity.

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