Transcript - Taking care season 2

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The cost of healthcare

Tash Miles: Ahpra acknowledges the Traditional Owners of country throughout Australia and the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past and present. Welcome to *Taking Care*, a podcast of Ahpra and the National Boards. I'm Tash Miles, and today we're talking about an issue that's relevant to most of us at some point in our lives, the cost of healthcare and, specifically, what it means when cost is a barrier to healthcare. It's always important, but it's probably particularly topical currently with inflation rising and most consumers being hit hard with the sharp cost of living increases across the board.

And fortunately, I have a fabulous panel of guests with us here today, coming from a range of different perspectives, and also, they're all from Tasmania. So I'd like to welcome Renate Hughes, who's a consumer advocate, Dr Chris Sanzaro, a dentist in northern Tasmania, and Associate Professor Amanda Neil, who's a health economist at the Menzies Institute for Medical Research in Hobart. Welcome. Renate, let's start with you. We're talking today about the cost of healthcare. What connection do you have with that conversation, and could you introduce yourself, please?

Renate Hughes: Yes, hello. So my name's Renate Hughes and I'm a consumer health advocate, but I guess my journey in healthcare has been quite a long one. So, coming from a professional background, having worked in teaching, social work and community development, I then encountered a health journey that was somewhat negative, and has been greatly impacted by cost of healthcare. So, at the moment, as well as being a consumer health advocate, I live with a disability and more than one chronic health condition. I'm on a fixed low income through the disability pension, and as a Tasmanian I live in a regional area of Australia. So that means at a local level I live in a socially and economically disadvantaged community, and I also live in public housing.

Tash Miles: Thanks, Renate. Chris, you're a dentist and you probably come to this conversation from a different direction. Could you tell us where you work and why you're interested in talking about this, please?

Chris Sanzaro: My name's Chris, I'm a dentist who owns and runs a dental practice in Launceston. It employs four other dentists, a couple of hygienists and myself in the practice. We work across a variety of different socioeconomic groups within that practice, and I've worked in government service as well as private practice over my nearly 20 years in dentistry. I'm also involved in the Australian Dental Association, I'm a Federal Executive Councillor, and so I'm aware of dentistry and access to care issue well outside just my own practice. I bring to it an interest in partnering with patients to form long-term relationships and achievable healthcare outcomes for them with their circumstances and working with people in that regard.

Tash Miles: Thank you, Chris. And Amanda, could you introduce yourself and tell us about the work that you do in relation to the cost of healthcare and its effect on our communities?

Amanda Neil: Thanks, Tash. So, my name's Amanda. I'm a health economist and population health researcher at the Menzies, as Tash mentioned. So as a health economist I'm really interested in the cost of care, and I look at that from a system level to an individual level. So, I was involved in a national study on the cost of psychosis, for example. I'm also interested in how individuals, how cost impact individual

decision making, and those costs are reflected both in terms of the individual consumer, but also how does cost, how does price, influence the supply of health services. It's really important at the moment with increasing costs of living, because certainly out-of-pocket costs are a major factor. Individuals actually contribute a fifth of the costs of all health expenditure in Australia on an annual basis through out-ofpocket costs.

Tash Miles: Just to follow on that, what did you mean when you spoke about the role of choice in the cost of healthcare?

Amanda Neil: I come from an economics background so it is, ultimately, it's about choices. Choices either to purchase healthcare or not to purchase healthcare, and cost, ease, or price is a major factor, and certainly there is data there that costs will influence decision making as to whether to actually see individuals. And, unfortunately, Chris, cost is, the greatest impact is, in relation to dentists in relation to out-of-pocket costs and the decision not to actually go and see a dentist.

Tash Miles: Renate, could you talk to us broadly about the costs associated with healthcare and how that might affect again the choice to seek healthcare or not?

Renate Hughes: In terms of cost factors and decisions, I have hundreds of stories of people, who have deferred or not engaged in healthcare and then ended up in an acute care situation. And, I mean, oral health is one of those situations. We know that oral health, and good oral health, is a key indicator for reducing other chronic diseases such as cardiovascular disease and general health and wellbeing and yet, for example, even for myself three weeks ago, I had put off for eight months a sore tooth, and mainly cost-related. I went to the dentist and had a filling, it cost me $260. They also did an x-ray, which I wasn't aware they were going to do, and that was an extra cost on top of that. So, that took more than 50% of my weekly income from my pension that week.

So I then, after having paid the rent, which I had to pay because I certainly don't want to become homeless, it left me no money for food or other bills. So you then get into a debt cycle that you have to try and make up with your next pension payment, and that becomes ongoing and cumulative. And even though, essentially, you can get a small loan, it would cover one episode of care. So, there are those sort of individual, personal issues, but at a structural level there are issues about the way that we package care, particularly for chronic healthcare packages and mental healthcare packages. The way that we structure them are not fit for purpose, so they're not fitted to the person, the person is fitted to the package.

Tash Miles: Drawing both on your personal experience, but also as a consumer advocate, if you could talk to us about some of the questions that people might ask to make it more about the person than about fitting into the existing system?

Renate Hughes: Questions you might want to ask, or want to know about, and what I have to say first is that there's an enormous amount of stigma and discrimination associated with discussions around cost of healthcare, and the fee for service system that we have. So, again, it's not the providers' fault because they're part of a broader system, and it's also not the health consumers' fault that they're not able to understand how the system operates and what it might cost in totality. So, for example, they might be asking questions about, what will it cost me each visit, and what will be the cost, total cost, of treatment if there's a series of visits, such as with a physiotherapist and a program of care.

They might ask, will my chronic healthcare package or my mental healthcare package cover the costs? What will I be out of pocket for, for each visit? Can I have a quote for the costs? What are the social costs of any treatment plan? So, for example, if I go to a dietician and they prescribe fresh fruit and vegetables, what's the cost of that on top of my living costs and my fixed low income? If I'm going to a podiatrist, the cost of orthotic inserts in my shoe, a walking stick, a walking frame. Some of these can be leased through government schemes, others cannot, depending on the needs of the person. How can I pay? Do I pay cash? Do I pay by card? Do you have a payment plan? Can I have time to pay? Can I defer the payment until my next pension date, for example.

And will there be any hidden costs? For example, will there be a dental x-ray that I wasn't aware of? Will there be a specialist maybe providing an injection as part of the appointment for steroids which is an additional charge at the visit? Are there other additional tests not covered by Medicare, such as allergy testing, for example. So these are all a whole lot of questions that consumers might want to ask, but what I also would say is that we have not been – health promotion needs have not been met in terms of increasing our health literacy and understanding of how to ask questions. What are the right kinds of questions to ask, and what we can expect from our healthcare services in terms of our healthcare rights as well as our responsibilities?

Tash Miles: And, I mean, all of those questions are asked after you've needed potentially to pay for travel to get to the appointment, to take time off work, for childcare, to attend it.

Renate Hughes: One excellent scenario would be, for example, a consumer that I know, a young mother with four children who lives in Brighton, which is a rural area. So the hospital keeps sending her appointments for 9 am in the morning. And, of course, if you don't attend your clinic appointments, you're either discharged from the list or you get a rather rude, sort of, punitive letter. She then has to get three buses to get into the city. She has to get her children to school, so she's got to get them there early or get someone to do child minding and then take them to school so she can catch the bus to get there on time for the 9 am appointment. She then has to have enough money to cover the bus fare.

Because she's been in such a rush, she hasn't eaten any breakfast, so she's probably going to need to grab something on the way into the clinic. Then she's going to have prescriptions from the clinic, which may or may not be fully covered under the Pharmaceutical Benefits Scheme, and any other additional referrals that she might have to have. So it isn't just one thing. It isn't just getting to an appointment, it's multiple steps to be able to even access the healthcare service and then, within the service, there are another whole lot of factors that come into play.

Tash Miles: Chris, you spoke in your intro about the importance of working in collaboration with patients. I guess my first question is, do you hear some of these questions that Renate has said that people should be empowered to ask, and what do you say, and how do you answer them?

Chris Sanzaro: Absolutely we hear those questions all the time. The stigma around cost discussions is something that really shouldn't be there. It should just be cited as one of the barriers. We have multiple barriers presented to us when people turn up trying to access to care. It could be their physical ability to get into a dental chair, it could be time away from work as we've discussed. It could be what's already existing in their mouths, what's already going on there. It would be ideal if everyone walked in with 32 perfectly happy, healthy teeth and we had to do very little to them because we've got a great foundation to start with, but we don't have that and so it's just another factor in considering what appropriate treatment options there are. It shouldn't have that stigma or taboo.

And certainly, it's easy to say that coming from a perspective, where I don't have to worry about that cost myself, but if that discussion is very open and honest right from the start it makes it a lot easier for everyone to be involved. So, those questions that Renate had are fantastic, they should start in the first place when you get in contact with the health service. There should be information available over the phone to give an idea. We're working in health, there's a whole bunch of things that are unpredictable, we don't know what we're going to be faced with. How big's the hole in the tooth? Is the tooth salvageable? All these sorts of things.

And so giving a definitive price is very difficult, but giving a range of price options, so it's not a surprise at the start of the appointment, because there can be that shock factor of, hang on, how am I going to do that today? And that then raises the emotional level, which makes it harder to then continue on conversation of panic in the chair, how am I going to cope with this? So if the information's there from the start, it's easier for the practitioner to work with that as well.

Tash Miles: And it's important to be easier because going to the dentist can be really expensive.

Chris Sanzaro: It's an expensive service to provide, for sure. We're running a mini hospital environment with sterilising equipment, and the cost of the equipment, and the high level of staff and labour in Australia is expensive, and you're not just paying for the dentist. You're paying for the assistant, you're paying for the receptionist, and for the sterilising staff as well. So there is a significant cost that comes with dentistry, and that's unavoidable. And so one of the really important things to factor in is having that cost discussion early on. What are the maintenance costs going to be? What are the hidden costs likely to be in the future?

And we don't have a crystal ball, unfortunately, it's not able to look well into the future and say, hey, this is exactly what's going to happen. But looking at it and going, okay, well, if you go down this sort of path, they come with higher maintenance costs. If you go down that sort of path it has the typically lower maintenance cost. And one of the things that's happening over time is, as our general and oral health is improving, we've got much fewer people, far fewer people, in full dentures come aged 60 or 70. People are holding onto their teeth for longer. That's fantastic, we're getting great health outcomes from that for general and social health, but that then means that the teeth that are there require high levels of maintenance, which takes a lot more time than replacing a set of dentures once every five or seven years.

Tash Miles: So, obviously you anticipate that cost is a big factor for your patients. Do you proactively state what the expected estimated cost will be? Or do you wait for the patient to ask?

Chris Sanzaro: No, it's a part of the discussion straight up usually, especially when there's multiple options available. It's one of those things, there's a lot to cover and there's a lot of pressure on practitioners and front desk. We've got COVID screening protocols at the front desk so it's easy for them to slip, accidentally slip past the, by the way here's the estimate for the upcoming appointment. Especially if we end up down a side-track of so-and-so's been sick in the house, what does that mean for quarantine, all those other sorts of things.

At our practice, we've got a little bit of a checklist to work through of, have we covered all those things, but it can be easy after several minutes on the phone call to accidentally skip over that and it's not an intentional thing. Usually when somebody comes into an appointment, if there's multiple treatment options, part of the discussion is what are the costs associated with this. Again, it can be one of those things that's easy to skip over if there's just one obvious option. It's like, this is the way to do it, and sometimes you get involved in the technical conversation around how it's going to last, what it's going to do, what are the procedural risks, gaining informed consent, and that sort of thing. But it should always be part of that conversation before any work is commenced, that people should be aware of the cost.

Tash Miles: Amanda, could we talk about healthcare more broadly? More broadly than just dentistry, about how you have seen patients prioritising or deprioritising their care when cost is a factor?

Amanda Neil: They do, and I'd be interested in Renate's thoughts here in relation to out-of-pocket expenses. I think everyone expects out-of-pocket expenses, but I think there is a question of the frequency of those expenses. If you're seeing someone regularly as opposed to, like, a dentist may be once or twice a year. If you're seeing, for example, a mental health professional for, you know, your up to 10 sessions, for example. In terms of those out-of-pocket expenses, there is this concern, and this goes back to what Chris' comments were in terms of what the actual expenses associated with running a business are, in terms of when a patient is experiencing ongoing out-of-pocket expenses, it really impacts what they can do, and they will choose not to have care, for example.

And certainly, in terms of, there is data there that psychiatrists, clinpsychs and so forth, the higher the outof-pocket expenses, the more likely a patient is to not progress care, to delay care, not attend care, and so forth. So out-of-pocket expenses can have a real impact on a service-by-service basis, and that is irrespective of what the treatment is, or irrespective of who the provider is, that is certainly a reflection. Out-of-pocket costs are impacting everything from medical services in terms of pharmaceuticals, in terms of general practitioners, potentially the least of all because they do sort of bulk-bill services more than other providers. So, out-of-pocket expenses are impacting, you know, decision making choices across the board in terms of healthcare utilisation.

Tash Miles: So, Renate, do you have any thoughts on what Amanda has just said?

Renate Hughes: Well, I guess it's not just about the impact of the out-of-pocket expenses, but that they're also fragmented. So, if we were to look, for example, at a chronic healthcare package and someone accessing that. They may be, instead of it being a sort of continuity of care between their primary healthcare provider and a range of services in a hub-type setting, it tends to be fragmented. So they might be sent off to a physiotherapist over there, a podiatrist over here, an occupational therapist there, a social support group down the road, and so what they then go through is this series of constant assessment and information gathering which takes up maybe two of the five chronic care sessions they've been given to start with.

None of that gets shared or recorded across, so the cost of care goes up because it's often repeated by several different providers, the same kind of care service, or there's not a coordination of what is available in a place-based local community area to meet that healthcare need. So it isn't just that there is

a gap, and there is always a gap that you pay, even with a package. You get about 75% back on average, so you can still be paying anything up to $30 or $40 for a physio visit, or to see a psychologist, for example, and if you're on a low fixed income such as a, say, disability pension that's quite a significant percentage of your weekly income.

So you've made that commitment. You've made that commitment to your healthcare journey, and your recovery journey if that's applicable. But then there are all these other obstacles that increase the cost. I look forward to ways that we can reduce that kind of fixedness in the system by creating more healthcare hubs that are place-based, community driven, and primary care driven.

Tash Miles: And Chris, from the practitioner perspective, obviously one way of reducing cost is to reduce the number of visits. Are there strategies that you employ to make more efficient when patients do come and visit you? Or other things to minimise cost for the patients?

Chris Sanzaro: One of the things we often work on is, how do we get to see people less often? If we're doing our job well as a practitioner, then we're working on prevention and ways of avoiding people coming back and seeking active care. Sometimes, unfortunately, the horse has bolted, but we can at least work on maintaining what remains there, and our goal within our practice is certainly to see people as least often as possible, which allows us to get on to do other things instead. I often say that if I wasn't doing dentistry because we've had the successful way of preventing all dental diseases, I'd find something else to do with my time, but we're not there yet, unfortunately. So having that discussion, what can I do better? How can I avoid coming back so often?

Yeah, one of the points that Renate raised earlier is the bouncing from practitioner to practitioner and spending a lot of that time establishing what's going on, and I often find that's one of the frustrations from patients that they feel they've got to tell their story again. I've witnessed it from family members attending hospitals and they're in the emergency department. Different practitioners come around, they've got to tell their story again and again, and they're frustrated by what appears to be a lack of communication. Being on the healthcare provider side of things, though, there's an element of, you need to hear from the patient firsthand what's going on.

What are their symptoms, how are they feeling, and all of that sort of stuff, because there's a real danger that if you're picking that up from other people that you're missing some subtleties in that. We often hear of diseases that are misdiagnosed or underdiagnosed or not diagnosed for an extended period of time, and so that process of going through re-telling your story, establishing what's going on, each person you're telling that to has got a different perspective that they're coming from. There's different filters, there's different things going on that day. You might put a different emphasis on things.

And so from a quality of care point of view it's actually a process that patients need to go through to get good quality of care, although it doesn't look like it on the receiving end. And then when you translate that into a private arrangement, that all takes time to sit down and discuss with people, and that's where we get back to the 'time is money' bit. So it is certainly a challenging area. I don't have a solution for that, but I acknowledge that that is a part of the problem.

Tash Miles: Amanda, just on the solutions, I wonder whether you could tell us if you've seen any kind of innovations, or workarounds, or any – that you think could become mainstream to kind of start to challenge some of these issues?

Amanda Neil: To me, there's a couple of things that I've been hearing in the conversation today, and one is that prevention is better than cure. And the importance of establish and maintaining relationships. If we could all have a GP or something that we can maintain, and a dentist that we can maintain that relationship that we don't have to repeat our background to. That, you know, that will certainly aid the efficiency of the system. Then I think there's the question of those of us within the community who currently have significant needs, particularly in terms of socioeconomic factors and if you have lots of chronic comorbidities, for example. Therefore, you know, they're often co-associated and, you know, which is leading to which?

So I think there's a question of, within the system, how can we look to support those who are most affected at the moment, while supporting prevention as we go? Health literacy, I think, is crucial in all of this, and this has been touched on throughout the conversation for all of us. Information is key to decision making. Some of the aspects that Renate was talking about, you know, this goes to case management, and there is certainly some of it in relation to people presenting to hospitals within Tasmania, in terms of acute care, in terms of frequent presenters, in terms of how can we actually –

taking a person-centric approach, in terms of what is their actual situation, and doing case management with them in terms of those with really high needs and high frequency presenters, for example.

If we can get some form of managed care for them to support them, to improve efficiencies, I think that will certainly aid the perspective of the consumer in terms of the individual who's needing care, and hopefully should aid the efficiency within the system as well.

Tash Miles: Renate, I'm wondering if you could talk to us about, I guess, or reiterate what you see as the priorities for safer care for patients and their families when it comes to accessible healthcare?

Renate Hughes: First of all, we make packaged care fit for purpose, so we fit it to the person, not to the package. So instead of having an arbitrary number of sessions, for example, each person, who is living with that chronic condition has a tailored package that is supported by their local GP service, and hopefully we will begin to shift the funding models and system models that base GP's essential services in the community. And within that service we have your GP, you have allied health, you have a nurse, you have a mental health worker, and we have a health hub. And that we also have an effective digital system through My Health and, first of all, we fix it, and then we embed some of the new and emerging tools.

For example, we've got the new national initial assessment referral tool, which is called IAR for mental health and support. GPs are able to then embed in their daily practice in gathering information with health consumers, use that tool digitally to help support their case management of individuals and families. And that doesn't replace communication on a one-to-one level. I agree with Chris that the personal relationship is central to effective healthcare. Trust, responsibility, and care, and working together as a team on your healthcare journey. So it's about workforce development, so developing our workforce so that they have, feel, that they can more effectively manage new digital systems and digital tools. That they can improve their communication skills with consumers, and that they understand emerging health systems, health literacy, health promotion, and other aspects of care.

So, it's about workforce development, it's about system change that doesn't necessarily have a cost, it's just about doing it better, and it's about refocusing care to individuals and tailored packages of care centralised at a local level.

Tash Miles: Thank you. Amanda, do you have anything that you'd like to add?

Amanda Neil: I'd like to highlight a couple of things that I think that can be easily done to assessed consumers, and they go to actually system level process factors. And we all have access to safety nets, for example, through Medicare, but if you have multiple people on a Medicare card, you actually have to register for that, everyone on that Medicare card to contribute to the same safety net. In terms of for pharmaceutical services, you actually have to physically ask your pharmacist to register you for the Pharmaceutical Benefits Safety Scheme. I don't see why that isn't being undertaken automatically and, again, why everyone on the Medicare card isn't being registered for the Pharmaceutical Benefits Safety Net.

So, again, I think there are things happening at a system level that could be undertaken comparatively efficiently, given the data that is being collected, that would actually support significant out-of-pocket costs. Pharmaceuticals being one of them. So, I think there is stuff that is happening at a system level. I'd also highlight there is actually a medical cost finder on the government, on the Department of Health's, website that enables you to compare costs or what the median cost is for a specialist within your area. Also about providing healthcare providers with information about what medical specialists, so your GP, providing information to your GP so they can understand what is being – what medical specialists will charge before they actually refer you on to various medical specialists and so forth. So, I think information is really key. We need to improve information across the board to consumers and providers alike.

Tash Miles: Chris, would you like to finish off with anything?

Chris Sanzaro: Talk to your healthcare provider. Open discussion, try and get over any stigma that's associated with it. Your healthcare provider's there to help you. They're there to work with you. There's no judgment around the ability to afford or not. It's one of the many barriers that we deal with on a regular basis, and we'll do our best to provide you with the best services we can, and work with you to see what we can achieve or refer you onto other places.

Tash Miles: And Renate, to round us out, do you have any further comments about what consumers should be able to expect from their health practitioner when it comes to the cost of the care that they're seeking?

Renate Hughes: I agree that a health consumer should be able to say, my healthcare team listens and understands my needs. They prioritise and respect my choices. They support me to set goals and achieve them in healthcare, and I don't miss services because of where I live, my income, my background, or my lived experience and healthcare journey.

Tash Miles: Well, thank you to my guests, Renate, Chris and Amanda, for really building a comprehensive portrait of what it looks and feels like when cost is a barrier to good healthcare, and what some of the strategies and resources are out there. You've woven lived experience with evidence in a really helpful way, so thank you.

Chris Sanzaro: Wonderful. Thank you so much for having me here.

Renate Hughes: Thank you, Tash, for this opportunity to talk, and to bring a consumer voice to the table to help improve our healthcare system.

Amanda Neil: Thanks so much, Tash, for having me on the panel for having such an important conversation for all of us.

Tash Miles: And to our listeners, thank you for joining us. We would love if you could subscribe, link to the podcast, share it with your friends and colleagues, and if you have any feedback, please email us at communications@ahpra.gov.au. Take care.

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