Chapter 2

Key issues

2.1 In general, witnesses and submitters supported the intent of the Bill (see chapter one) but expressed concerns with either the proposed cap on expenses that can accumulate toward the safety net threshold or the proposed cap on safety net benefits. These matters are discussed below.

Justification for the New Medicare Safety Net

2.2 Some witnesses and submitters acknowledged the rationale and evidence base identified by the Hon Sussan Ley MP, Minister for Health (Minister), for reform of the current safety net arrangements.[1] Dr Lesley Russell (appearing in a private capacity) told the committee:

> …reforms to the Medicare Safety Net arrangements are long overdue. There is considerable evidence that the current arrangements are inequitable, do not benefit those with the greatest need and continue to be inflationary. This has led to increasing economic pressures on patients from rising out-of-pocket costs, with consequences for their health outcomes, quality of life and hospital budgets.[2]

2.3 Professor Kees Van Gool, Deputy Director of the Centre for Health Economics Research and Evaluation (CHERE), and an author of the two Extended Medicare Safety Net (EMSN) reviews, stated:

> …the reforms are a step in the right direction because they no longer reward highly excessive fees. They will simplify how the caps are set and the lowering [of] the threshold for concession card holders is likely to benefit more lower income households as well as singles. However, for these reforms to be more effective, we need greater transparency on fees and the fees charged by doctors. The reforms will place greater onus on competition and, for competition to work, patients in particular need information about the fees that doctors charge.[3]

2.4 Professor Van Gool suggested that patients and general practitioners (GPs) should be provided with information on fees before a referral is written for specialist service:

> …a very simple way would be to make that sort of information available on the internet. Providers would not have to provide their personal details. But you could get an average charge for item 104, which is an initial

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1 For example: Dr Michael Daubney, Chair, Binational Committee, Faculty of Psychotherapy, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, 16 November 2015, p. 21; Dr Matthew Ritson, *Submission 13*, p. 1.

2 *Committee Hansard*, 16 November 2015, p. 7.

3 Deputy Director, Centre for Health Economic Research and Evaluation (CHERE), *Committee Hansard*, 16 November 2015, p. 9.

> specialist consultation, on the internet for a particular postcode. That at least would put some knowledge in the GP's hands about whether the specialist they are referring to actually does bill in line with that average.[4]

2.5 The committee understands that Professor Van Gool was proposing 'an information tool' based on data that is currently held by the Department of Health (Department) and various other agencies, either at an aggregate or local level.[5] The committee considers that this could be a useful means of assisting patients and their GPs to determine, and choose to utilise, an affordable service.[6] The committee notes:

> Minister Ley has publicly signalled her interest in this area, and the department is undertaking some investigation into it…it is probably a longer-term agenda, because it is going to require quite considerable discussion with the professions involved, consideration of privacy issues, and so on. But, certainly, from a policy standpoint an approach to preventing fee inflation is more transparency in fee charging.[7]

New Medicare Safety Net Threshold

2.6 Proposed section 10DC of the Bill proposes three new thresholds, two of which are lower than the existing EMSN thresholds.[8] The Department estimated that the lower thresholds will enable an additional 53,000 people to access benefits under the new Medicare Safety Net.[9]

> Overall, this means there will be a relative shift towards concessional access and increased access for single people without concession cards. In addition, it is expected the accumulation benefit arrangements will mean the proportion of benefits flowing to people currently charged up to 150 per cent of the current MBS Fee will increase, meaning a greater share of safety net benefits for those in lower socioeconomic areas.[10]

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4 CHERE, *Committee Hansard*, 16 November 2015, pp 11–12. Also see Dr Lesley Russell, *Committee Hansard*, 16 November 2015, p. 12.

5 CHERE, *Committee Hansard*, 16 November 2015, pp 11–12.

6 Also see: Ms Josephine Root, Policy Manager, Consumers Health Forum of Australia (CHFA), *Committee Hansard*, 16 November 2015, pp 33–34, who argued that consumers in a limited market are 'price takers' rather than 'price makers'.

7 Mr Andrew Stuart, Acting Secretary, Department of Health (Department), *Committee Hansard*, 16 November 2015, p. 46.

8 The threshold for Family Tax Benefit Part A recipients will increase slightly, from $638.40 to $700.00.

9 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 35. Mr Stuart noted that 53,000 is a net figure, comprised of 80,500 more concession card holders and 27,500 fewer non-concessional people receiving benefits.

10 Department, *Submission 18*, p. 3.

Ability to reach the new threshold

2.7 Submitters and witnesses supported lowering the safety net thresholds. However, in view of proposed section 10P, which would limit the total amount of out-of-pocket expenses for a service that can accumulate toward the threshold, witnesses expressed concerns about people's ability to meet the new threshold.[11]

2.8 Professor Van Gool, for example, highlighted the two countervailing effects:

> …on the one hand, the lowering of the thresholds—having lower thresholds for singles as well as generous rules for defining a family will lead to more people qualifying; on the other hand, the limitation on the out-of-pocket costs that contribute to the thresholds will make it harder to qualify.[12]

2.9 Dr Bastian Seidel, representing the Royal Australian College of General Practitioners (RACGP), agreed that, in respect of general practice consultations, it will be more difficult to reach the new threshold:

> Currently, it would take, let's say, [around] about 16 consultations before you reach the safety net covered by the general practice consultation; under the proposed bill it would be 21 visits.[13]

2.10 According to witnesses, the practical effect of not reaching the new Medicare Safety Net threshold is that a person would not qualify for this financial assistance with their out-of-pocket costs, making healthcare more expensive and perhaps not affordable.

More equitable distribution of benefits

2.11 The Statement of Compatibility with Human Rights in the Explanatory Memorandum (EM) to the Bill notes that benefits under the new Medicare Safety Net would be 'more equitably distributed between socio-economically advantaged and disadvantaged areas'.[14]

2.12 Some witnesses considered it difficult to gauge who would benefit from the measure proposed in the Bill—sometimes due to a lack of published data and

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11 For example: Ms Josephine Root, CHFA, *Committee Hansard*, 16 November 2015, p. 32.

12 CHERE, *Committee Hansard*, 16 November 2015, p. 8.

13 Tasmanian Faculty, Royal Australian College of General Practitioners, *Committee Hansard*, 16 November 2015, p. 2. General practice consultations account for only a small amount of EMSN expenditure. In 2011, this amounted to $40.0 million of $311.8 million in expenditure: CHERE, *Extended Medicare Safety Net, Review of Capping Arrangements Report 2011*, 2011, p. 24, http://www.health.gov.au/internet/main/publishing.nsf/Content/2011_Review_Extended_Medicare_Safety_Net/$File/Final%20Report%20-%20Review%20of%20EMSN%20benefit%20capping%20June%202011.pdf (accessed 20 November 2015).

14 Explanatory Memorandum (EM), Statement of Compatibility with Human Rights, p. 10.

modelling—and whether the Bill would result in a more progressive distribution of safety net benefits.[15]

2.13 Professor Van Gool questioned whether the Bill would lead to a change in the type of people who qualify for a rebate under the new Medicare Safety Net, noting that the Bill would likely have some redistributive effect toward lower income households:

> The answer depends on how many concession card families experience annual costs between $400 and $638 and the general families with out-of-pocket costs between $1,000 and $2,000 because these are the people who stand to benefit under the new arrangements. If there are more people in the former, in the concession card group, than in the latter, I would expect a change in the threshold could lead to a more progressive distribution of safety net benefits—that is, the safety net benefits should be more going towards poorer communities or less wealthy areas. It should be noted that concession card status is a poor proxy for household income. There are many poor households who do not have concession cards and there are many wealthy families who do…I do think that the lowering of the threshold for concession card holders is likely to benefit more lower income households, as well as singles. That should have some redistributive effect on where the safety net benefits are going.[16]

2.14 Professor Van Gool indicated that capping the total amount of out-of-pocket expenses for a service that can accumulate toward the threshold would also impact how many and what type of families qualify for safety net benefits:

> To some extent, this part of the reform will disadvantage those who seek services where the doctor fees are substantially above the Medicare Benefits Schedule [(MBS)]fee but should have less impact on those who see doctors who charge within the 150 per cent of the MBS fee. This reform may invoke a number of changes on behalf of doctors and patients seeking to derive maximum benefits from the safety net, in particular create greater incentives for patients to seek out doctors who charge within the 150 per cent of the Medicare schedule fee. This in turn may invoke some more price competition amongst doctors. Another potential impact is that doctors may redistribute their fees across items so that the fees across an episode of care are better in line with the inherent incentives of the policy. Of course another potential impact is that they may increase the volume of services or try to increase the demand for the volume of services.[17]

2.15 Dr Dion Forstner, Dean of the Faculty of Radiation Oncology at the Royal Australian and New Zealand College of Radiologists (RANZCR), rejected any

15 Australian Medical Association (AMA), *Submission 6*, p. 2. Dr Lesley Russell, *Committee Hansard*, 16 November 2015, p. 10; Ms Josephine Root, CHFA, *Committee Hansard*, 16 November 2015, pp 32–33.

16 CHERE, *Committee Hansard*, 16 November 2015, pp 8 and 12.

17 CHERE, *Committee Hansard*, 16 November 2015, p. 8.

suggestion that the Bill would affect only those in socio-economically advantaged areas:

> …a significant number of patients that access radiation therapy come from a low-socioeconomic group…with private centres as the only accessible centres in some areas, those of lower socioeconomic status do access the private sector and would be impacted by a need to pay a larger gap.[18]

2.16 Dr Forstner added that the need to pay higher out-of-pocket costs would create 'some movement of patients from the private to the public sector', with consequences for the viability of private practices and the subsequent impact on public centres.[19]

Department response

2.17 The Department informed the committee that 'the design of the new Medicare safety net is evidence based'. In particular, the findings of the two independent reviews have been used to set the parameters for the safety net, informed also by current Medicare data.[20]

2.18 In its submission, the Department provided data about the current distribution of EMSN benefits, highlighting that there continues to be inequity in the distribution of these benefits across geographical areas, including by remoteness areas and based on the socio-economic index for areas (SEIFA). For example, according to SEIFA, Decile 10 (most advantaged) received 30.4 per cent of EMSN expenditure in 2013–14, compared to Decile 1 (least advantaged) which received 2.2 per cent of EMSN expenditure for the same period.[21]

2.19 The Department also set out some data in relation to the impact of the Bill on three particular services:

- radiation oncology services—an additional 1,000 people (including 800 concession card holders) will receive safety net benefits under the new arrangements due to lower thresholds;
- psychiatry services—an additional 2,300 people will receive safety net benefits for psychiatry services; and
- assisted reproductive technology— the vast majority of patients will not be financially impacted for their first IVF cycle but will receive about $850 less for the second IVF cycle.[22]

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18 Dean, Faculty of Radiation Oncology, Royal Australian and New Zealand College of Radiologists (RANZCR), *Committee Hansard*, 16 November 2015, p. 13. Also see: RANZCR, *Submission 14*, pp [1–2[; Dr Rachel Falk, *Submission 11*, p. 2, who made similar arguments.

19 RANZCR, *Committee Hansard*, 16 November 2015, p. 14.

20 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 36.

21 Department, *Submission 18*, pp 11–12.

22 *Submission 18*, pp 20–23.

2.20 The Department submitted that GP services currently account for only 0.7 per cent of EMSN expenditure, as fees for these services are generally low and there is a high bulk billing rate (91.3 per cent for concession card holders). This means that concession card holders are unlikely to be affected by the Bill. Further:

> The majority of people receiving safety net benefits for a GP service have qualified for benefits from specialist services that year. In relation to qualifying for the EMSN via GP visits only, a concessional person, charged the 2014 average fee of $67.80, would qualify on their 21st service. Under the new arrangements the same person would qualify on their 22nd service.[23]

2.21 The estimates were based on current patterns of safety net use and charging by clinicians (specialists). However, the Department emphasised that the enactment of the Bill is expected to change these behaviours:

> …we actually expect that fee-charging behaviour will change. Fee-charging behaviour changed when the new safety net was introduced…
>
> With the changes in the incentives that this bill brings forward, we would expect to see, again, a shift back, a changing in the pattern of charging by specialists. But, assuming that that does not change, 80,000-plus more concessionals will obtain benefits. We think that that number could be larger, and we think that the losses that would be predicted to non-concessionals could actually be lower if fee-charging behaviour actually does change.[24]

Medical Benefits Schedule Review

2.22 Some witnesses referred to the fluid environment in which the Bill has been introduced and, in particular, to the Medical Benefits Schedule Review (MBS Review) that was announced by the Government in the 2015–16 Budget.[25] It was argued that the introduction of the Bill is premature, as the MBS Review is not due to report to the Minister until December 2015 (an interim report) and December 2016 (the final report containing recommendations).[26]

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23 Department, *Submission 18*, p. 23.

24 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 36. Also see: National Association of Practising Psychiatrists (NAPP), *Submission 19*, pp 3–4; Dr Matthew Ritson, *Submission 13*; RANZCR, *Submission 14*, p. [3], who argued that, in their respective areas, there is no room for further fee reductions.

25 Australian Government, *Budget measures: budget paper no. 2: 2015–16*, 2015, p. 104, http://www.budget.gov.au/2015-16/content/bp2/download/BP2_consolidated.pdf (accessed 20 November 2015). The Medical Benefits Schedule Review taskforce has been appointed to consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients, including a review of Medicare Benefits Schedule items and their described service.

26 For example: Ms Josephine Root, CHFA, *Committee Hansard*, 16 November 2015, p. 34.

2.23 For example, Dr Forstner told the committee that his organisation is concerned about the number of major changes concurrently affecting the small specialty of radiation oncology, without any apparent coordination:

> The safety net change is just one of those. We are awaiting the outcome of a review by the National Audit Office on Radiation Oncology Health Program Grants, which are fundamental to the replacement of our equipment—so capital expenditure. We obviously have the MBS review, which we are very keen to participate in…We have had two major [Medicare Services Advisory Committee] applications in for several years now[.][27]

2.24 Dr Forstner indicated that, if the outcome of the MBS Review were a modernisation of MBS fees such that they recognised the cost of providing treatments, then RANZCR would be more inclined to support the Bill and, in particular, the 150 per cent safety net benefits cap.[28]

2.25 The committee heard from the Department that the Bill has been introduced separate to the MBS Review, and other reviews, as the proposed legislation deals with a 'separate and different kind of problem'. An officer emphasised that the Bill focuses on 'access and costs in relation to patients', rather than clinical efficacy which is the focus of the MBS review. Further:

> …the safety net was never implemented with a consideration that it was a tool to support the income of clinicians. The safety net was implemented with the view that it was a tool to prevent excessive cost to patients. The real problem about where we are now and why we are here now with this legislation is that it has become a tool which is about income for clinicians, and that is corrupting the purpose of the safety net, and we now have a significant problem to solve.[29]

2.26 The Department noted that the Bill also has a role to play in the development of longer-term policy and healthcare reform:

> …implementation of the Medicare safety net changes now will provide transparency and certainty, which can then be taken into consideration by longer-term work programmes of the MBS Review Taskforce and the Primary Health Care Advisory Group.[30]

Increased provider fees

2.27 The committee notes evidence that suggests provider fees have been noticeably influenced by changes to the EMSN. Dr Russell told the committee that the

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Department of Health, *The MBS Review Taskforce Process* webpage, http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSRTprocess (accessed 20 November 2015).

27 RANZCR, *Committee Hansard*, 16 November 2015, p. 13.

28 RANZCR, *Committee Hansard*, 16 November 2015, p. 16.

29 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 40.

30 *Submission 18*, p. 24.

main driver of out-of-pocket costs are specialist fees and, in the past 10 years, the data tells a 'story of pressures and policy influences':

> Although the average bulk-billing rate has barely changed for specialists, the average out-of-pocket costs have more than doubled, from $32.66 to $70.89. For individual specialties there have been some dramatic changes. Most obviously, the bulk-billing rates for obstetrics—currently 51.5 per cent—was only 21.8 per cent in the June quarter of 2005. We can assume that this is due to the increases in the Medicare reimbursements that were made as part of an effort to tackle the inappropriate use of the Extended Medicare Safety Net. The bad news is that those obstetricians who do not bulk bill have continued to increase their fees and the patient's average contribution has risen from $51.75 in 2005 to $247.79 today.[31]

2.28 Professor Van Gool similarly noted that the 2011 review found that the introduction of capping arrangements in 2010 had a number of unintended effects on charging practices:

> We found evidence of providers changing their fee structures—reducing fees for capped items but increasing them for uncapped items. The review found evidence of this among providers of plastic and reconstructive surgery services. In addition, the review found evidence of an increase in doctor fees of uncapped items that were complementary to capped items. As the out-of-hospital fees for the cataract surgery items were falling, the provider fees for anaesthesia for linked surgery increased substantially. The new safety net will make it harder for these effects to take place. The shift in billing practice between capped and uncapped items should no longer occur under the reforms.[32]

2.29 The Department also commented on EMSN expenditure over the period 2004–2014, highlighting that 'in some areas, this expenditure is continuing to increase rapidly as a result of increases in the fees charged by providers' (see Table 2.1).[33]

Table 2.1: Extended Medicare Safety Net expenditure, 2004–2014

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
EMSN expenditure ($ million)	$164.4	$272.2	$248.9	$319.3	$414.1	$516.2	$342.2	$369.0	$409.4	$394.1	$423.5
% change from previous year		63.5	-8.8	28.6	29.7	24.7	-33.7	7.8	10.9	-3.8	7.5

Source: Department of Health, Submission 18, p. 9.

2.30 The Department advised that, by 2019–2020, EMSN expenditure is projected to reach the same level as before capping was introduced. Its submission contained a

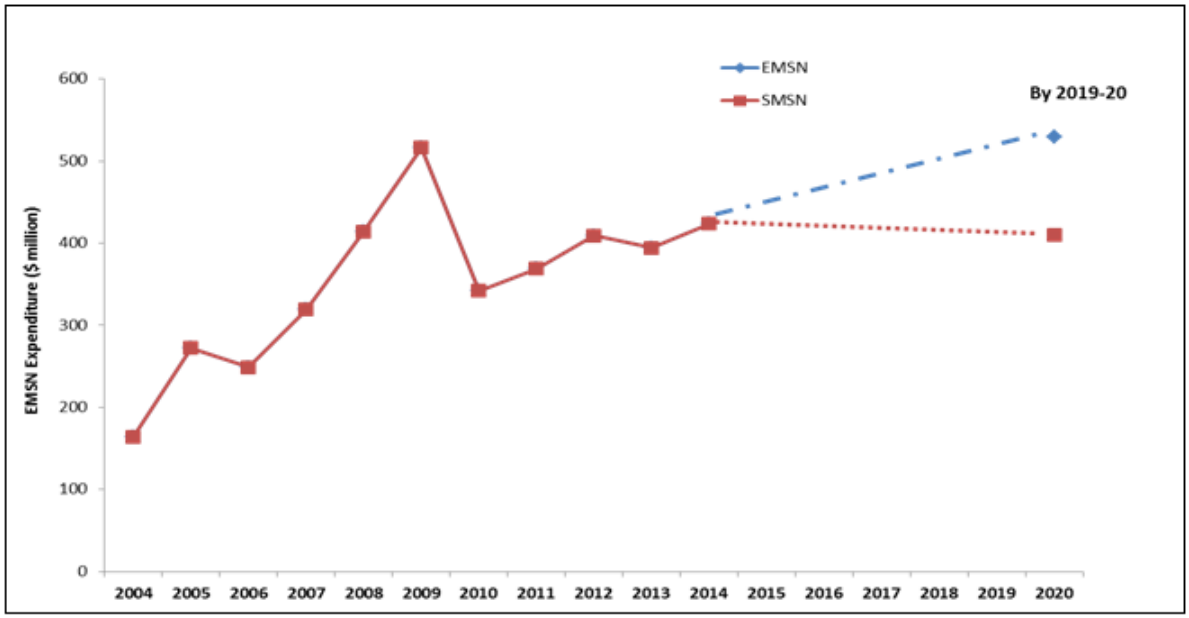
31 *Committee Hansard*, 16 November 2015, p. 7.

32 CHERE, *Committee Hansard*, 16 November 2015, p. 9. Also see: Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 37; Mr Michael Ryan, Acting Assistant Secretary, Department, *Committee Hansard*, 16 November 2015, p. 37.

33 *Submission 18*, p. 9.

useful comparison of this projection and the new Medicare Safety Net estimated expenditure (Figure 2.1).

Figure 2.1: Extended Medicare Safety Net expenditure and new Medicare Safety Net expenditure (projected), 2014–2020



Source: Department of Health, Submission 18, p. 10.

2.31 The committee heard that, subsequent to the introduction of caps on some MBS items in 2010, there was some moderation in those providers' fees. However, for uncapped MBS items—such as radiation oncology where fees significantly increased in 2013–14—fee inflation and a corresponding increase in out-of-pocket costs is now being observed.[34]

2.32 The Department submitted:

> The introduction of safety net benefit caps for all MBS items is expected to have a moderating effect on fee inflation, as demonstrated after the introduction of capping on obstetrics and other services, such as eye injections.
>
> …one of the main incentives for fee inflation was the ability for people to cross the threshold of the EMSN in a single high fee service. The new Medicare safety net will respond to this issue by introducing a cap on the amount per service that can count towards the threshold.[35]

Interaction between Medicare Benefits Schedule fees and the Bill

2.33 Some witnesses and submitters raised the issue of MBS fees and how the current fee levels might interact with the proposal to introduce a 150 per cent cap on benefits under the new Medicare Safety Net. Essentially, these witnesses argued that it

34 Department, *Submission 18*, p. 15.

35 *Submission 18*, p. 2.

would no longer be financially viable to continue to provide some services, as the MBS does not recognise the costs of providing the service and there would be no capacity to recover those costs through the new Medicare Safety Net.[36]

2.34 For example, Dr Forstner gave the following evidence:

> The MBS items are well underfunded. They have not been changed in many years, and they have not kept up at all with the changing technology that has occurred over the last 15 years. We have long been aware that, for a private centre to keep its head above water, there needs to be in excess of the schedule fee charged, and we believe that most of that safety net component, which I think is about 13 per cent of what the MBS pays to radiation oncology, is in fact due to the inadequate reimbursements rather than any sort of scheming or manipulation of the system.[37]

2.35 GenesisCare, the largest provider of radiation oncology in Australia, made similar comments regarding the current level of MBS fees. Its evidence suggested that evidence based MBS fees—potentially to be delivered though the MBS Review—could work in tandem with the 150 per cent benefits limit proposed in the Bill:

> The MBS is out of date and in many cases does not reflect cost of service provision. As such, a flat cap of 150 per cent, in many cases, puts federal funding well below the cost of service delivery. The safety net has provided a mechanism for private providers to manage these funding inequities to date. We are keen to work with the department to resolve these funding inequities through the MBS review; however, to cap benefits ahead of the review is unsustainable.[38]

2.36 In response to these concerns, an officer from the Department emphasised that the measure in the Bill is patient focussed:

> …consultation with various professions has highlighted that the top-up to the MBS rebate provided by the safety net has masked the dissatisfaction of some providers with the underlying MBS item fee structure and other aspects of remuneration...the safety net is not a reimbursement or remuneration policy; it is a policy to protect the patients.[39]

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36 For example: AMA, *Submission 6*, p. 1; Dr Shirley Prager, President, NAPP, *Committee Hansard*, 16 November 2015, p. 19.

37 RANZCR, *Committee Hansard*, 16 November 2015, p. 13. Also see p. 16.

38 Mr Keith Hansen, GenesisCare, *Committee Hansard*, 16 November 2015, p. 26. Mr Hansen informed the committee that the potential impact of the Bill might be the closure of private centres, the retirement of medical professionals, and the withdrawal of services, with consequences for vulnerable patients and downstream costs: pp 29–31. However, the Department did not believe there would be impacts in terms of the delivery of health services: Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 44.

39 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 35. Also see: Department, *Submission 18*, p. 4.

New Medicare Safety Net benefits cap

2.37 Proposed section 10R proposes to limit the total rebate on all MBS items to 150 per cent of the MBS fee for that service (the current cap for some services is 300 per cent). Some witnesses argued that the proposed provision will make services more expensive for patients, as not all out-of-pocket costs will be rebated.[40] The committee heard that this would especially affect patients with high medical needs—such as multiple, complex and chronic conditions.[41]

2.38 Mr Keith Hansen, the Executive Manager of Cancer Care for GenesisCare, told the committee that the safety net is the only insurance available to patients who are not treated in the public health system:

> With higher out-of-pocket costs, the legislation will…reduce the incentive for patients to utilise private services, where they are currently making a meaningful and direct contribution towards the cost of their care…The outcome of the policy will be that more patients will be forced to seek care in the public hospital system, where capacity is already limited and care is often more expensive to deliver. In many cases, this will mean longer wait times, increased travel burden and some patients not receiving treatment, which will result in adverse health and social outcomes. When taken together, it is highly likely that this policy will, in fact, increase costs across the healthcare system.[42]

2.39 The Department did not agree with this assessment of the public health system, telling the committee:

> …60 per cent of radiation oncology is provided in the public system. There was a report last week by the [Australian Institute for Health and Welfare] that accessibility is high and waiting times are low for the public system. Of the remaining 40 per cent, about [seven] in 10 of those services are provided by GenesisCare—so about [28] in every 100 are provided by GenesisCare, and they have been growing very rapidly.
>
> I do not have any particular problem with that. It is just to point out that the main alternative to GenesisCare now is not another private provider;

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40 AMA, *Submission 6*, p. 1; Private Mental Health Consumer Carer Network (Australia), *Submission 8*, p. 3; Australian Psychoanalytical Society, *Submission 9*, p. [3]; Dr Katie Dimarco, *Submission 10*; Fertility Society of Australia, *Submission 24*, p.1; Dr Bastian Seidel, RACGP, *Committee Hansard*, 16 November 2015, p. 1; Mr Andrew Paine, Senior Analyst for Economics, RANZCR, *Committee Hansard*, 16 November 2016, p. 14; Mr Keith Hansen, GenesisCare, *Committee Hansard*, 16 November 2015, p. 26; Ms Josephine Root, CHFA, *Committee Hansard*, 16 November 2015, pp 32–33.

41 For example: Australian Psychoanalytical Society, *Submission 9*; Dr Melinda Hill, *Submission 27*.

42 *Committee Hansard*, 16 November 2015, p. 26. In contrast, intensive psychiatric treatment is not available in the public sector which could result in those patients having no alternative but to seek treatment in private centres: Dr Shirley Prager, NAPP, *Committee Hansard*, 16 November 2015, p. 18; Dr Gil Anaf, Vice President, NAPP, *Committee Hansard*, 16 November 2015, pp 18–19.

> the main alternative is a public provider and that they provide good-quality care, accessibility and timeliness.[43]

2.40 Mr Andrew Paine, the Senior Analyst for Economics at RANZCR, expressed similar concern that the safety net benefits cap will disadvantage patients with chronic medical needs, as most patients will have reached the 150 per cent cap by the time they need to access radiation therapy (particularly in the area of breast cancer). Mr Paine argued that, in seeking to increase access to safety net benefits through lower thresholds, funds have been redirected away from the benefit amount with the proposed cap:

> People will reach the threshold earlier, but it is the chronic patients we are concerned about—the ones with cancers for which there are…huge Medicare expenditures or medical bills. It seems like the funding is going to be transferred away from those chronic patients towards other people to allow them to hit the threshold earlier.[44]

2.41 Dr Michael Daubney from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) highlighted concern for the continued treatment of patients who require intensive psychotherapy services:

> People with mental illness remain a particularly disadvantaged group in our community. They suffer lower life expectancy, poorer employment and education outcomes and frequently experience discrimination in a wide range of areas. It is our belief that the bill, as it is proposed, will unintentionally discriminate against those most in need of intensive psychotherapy and therefore exacerbate the poor mental health of a small but important group of Australians.[45]

2.42 In respect of intensive psychiatric treatment, Dr Shirley Prager, President of the National Association of Practising Psychiatrists (NAPP), told the committee that patients might not be able to continue treatment if the Bill, as currently drafted, is enacted:

> We are concerned that [patients] will not be able to afford the $200 or more per week for out-of-pocket expenses. Their psychiatrists will not be able to lower their fees, because they will not be able to cover their overheads and make a living. There is likely to be an increase in suicides and homicides. Patients who are able to [function] with this treatment are likely to be unable to work, and will be likely to go onto the disability pension.

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43 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 36; Department, correspondence dated 19 November 2015 (received 19 November 2015).

Also see: Australian Institute of Health and Welfare, *Radiotherapy in Australia: report on a pilot data collection 2013–14*, Cat. no. HSE 167, Canberra, 2015, http://www.aihw.gov.au/publication-detail/?id=60129553437 (accessed 20 November 2015).

44 *Committee Hansard*, 16 November 2015, p. 14. Also see: RANZCR, *Submission 14*, p. [2].

45 *Committee Hansard*, 16 November 2015, p. 21. Also see: Dr Anne-Marie Swan, *Submission 26*, p. 1.

> There may also be increased security risks, particularly in adolescent patients.[46]

2.43 The Private Mental Health Consumer Carer Network (Australia), NAPP, RANZCP and GenesisCare supported legislative exemptions for certain MBS items, to enable continuity of access to services for patients who would not be able to afford treatment if the Bill were enacted with a 150 per cent cap on safety net benefits.[47]

2.44 The committee heard that GenesisCare had earlier proposed a temporary 195 per cent cap for radiation oncology MBS items. Mr Hansen explained:

> This amendment has the benefits of maintaining access to patient care, protecting the government against any potential future price increases, and delivering the bulk of budget savings. We earnestly request a temporary cap be implemented for radiation oncology so we can actively support what we believe is a reasonable and necessary change in policy. By working with the government and the medical profession through the MBS review, we can unlock real efficiency and innovation in the healthcare system, which will drive long-term sustainability and improve health outcomes.[48]

2.45 Ms Josephine Root, Policy Manager for the Consumers Health Forum of Australia, told the committee that, in the absence of modelling, it is difficult to determine precisely what cap percentage might be appropriate, to ensure access to healthcare:

> You would have to look at the 150 per cent figure if you were wanting to get a better [health] outcome and…you need to look at what people are actually paying. It is tricky to quickly come up with something which is going to work better unless we can have a closer look at what people are actually paying. I think more work needs to be done on the modelling and the rationale for the 150 per cent. I have not seen it in detail; I would like to see it.[49]

2.46 The committee notes that the Department consulted some stakeholder groups following the budget announcement of the new Medicare Safety Net measure[50] and

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46 *Committee Hansard*, 16 November 2015, p. 18. Many mental health treatments are not available in the public sector: NAAP, *Submission 19*, pp 2–3; Medicare Working Party, Australian Psychoanalytical Society, *Submission 28*, pp [3–4]; Dr Michael Daubney, RANZCP, *Committee Hansard*, 16 November 2015, p. 20.

47 Private Mental Health Consumer Carer Network (Australia), *Submission 8*, p. 4; Dr Shirley Prager, NAPP, *Committee Hansard*, 16 November 2015, p. 24; Dr Michael Daubney, RANZCP, *Committee Hansard*, 16 November 2015, p. 25.

48 *Committee Hansard*, 16 November 2015, p. 27.

49 CHFA, *Committee Hansard*, 16 November 2015, p. 34.

50 Ms Natasha Ryan, Assistant Secretary, Medical Specialist Services Branch, Department, *Committee Hansard*, 16 November 2015, p. 38.

that the arguments presented by stakeholders were considered by Government prior to the Bill's introduction into Parliament.[51]

2.47 GenesisCare was one of these stakeholders and, in relation to its capping proposal, the Department concluded:

> …that the current measure is the best one to go forward with. The essential problem is that the more you raise the cap, the higher the costs and the greater the inflationary impact will be. We are looking for behaviour change from the clinicians…We have looked at a range of options for advice to the minister and the government. This is quite a wicked problem. …we are satisfied that the arrangements are simpler, more progressive and less inflationary than the existing arrangements; therefore, better and superior. Patients will find them a lot easier to understand, so will clinicians, and they will have a less inflationary impact.[52]

Committee view

2.48 The objective of the EMSN is to provide financial assistance to families and singles whose out-of-pocket healthcare costs reach an annual threshold. Evidence presented to the committee showed that, over more than 10 years, this program has achieved inequitable and inflationary outcomes, failing to deliver affordable access to high quality healthcare. The Bill proposes to remedy this situation and, in the process, eliminate complexities and inconsistencies that have arisen within the Medicare safety nets. The committee therefore supports the introduction of the new Medicare Safety Net, as proposed in the Bill.

2.49 The committee acknowledges however that various stakeholders have concerns about the proposed measure. To some degree, the lack of publicly available data and modelling on the impact of the measure has caused unnecessary angst and confusion. The committee notes that there is an evidence base to support the Bill, some details of which were provided only on the request of the committee. The committee considers that the imminent introduction of a new safety net with fundamental parameter changes warrants explanation as to its anticipated effect and that the EM to the Bill should be amended accordingly.

2.50 A particular issue to emerge from the evidence was that there is a great deal of uncertainty about how the new Medicare Safety Net will operate and whether it will achieve its stated objectives. The committee considers that it would be highly beneficial to review these matters no more than five years after commencement of the program, so that any shortcomings can be quickly identified and resolved.

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51 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 41. Also see: Mr Keith Hansen, GenesisCare, *Committee Hansard*, 16 November 2015, p. 31.

52 Mr Andrew Stuart, Department, *Committee Hansard*, 16 November 2015, p. 38.

2.51 The committee makes the following recommendations:

Recommendation 1

2.52 The committee recommends that the Department of Health amend the Explanatory Memorandum to the Bill, to explain the data and modelling underpinning the Bill, particularly the anticipated impact of the Bill on the Australian community.

Recommendation 2

2.53 The committee recommends that the Bill be amended, to include a review of the operation and outcomes of the new Medicare Safety Net no later than 1 January 2021.

Recommendation 3

2.54 The committee recommends that the Bill be passed.

Senator Zed Seselja

Chair