



# The Royal Australian and New Zealand College of Radiologists®

## The Faculty of Radiation Oncology

19 November 2015

The Senate Community Affairs Legislation Committee  
[community.affairs.sen@aph.gov.au](mailto:community.affairs.sen@aph.gov.au)

Dear Committee Members,

### RE: Health Insurance Amendment (Safety Net) Bill 2015

I am writing to you on behalf of the Faculty of Radiation Oncology (The Faculty) of the Royal Australian and New Zealand College of Radiologists (RANZCR) – the peak body advancing patient care and the specialty of radiation oncology through the setting of quality standards, producing excellent radiation oncology specialists, and driving research, innovation and collaboration in the treatment of cancer.

We thank the Senate Community Affairs Legislation Committee for the opportunity to appear at the public hearing on Monday 16 November 2015, to express the Faculty's concerns about elements of the Health Insurance Amendment (Safety Net) Bill 2015. In addition to our participation in that hearing, this submission is intended to emphasise the Faculty's key concerns, as well as to respond to some of the issues raised by the Department of Health in relation to the use of the Medicare Safety Net and the Extended Medicare Safety Net (EMSN) by private radiation therapy practices.

The current utilisation rate for radiation therapy (which could benefit about one in two cancer patients) is still significantly below the optimal utilisation rate for Australian cancer patients<sup>1,2</sup>.

The Faculty's concerns regarding the proposed changes to the Medicare Safety Net are based on the principle of ensuring affordable and timely access to radiation therapy for all cancer patients in Australia – keeping in mind that currently about 40% of radiation therapy treatments are delivered in the private sector.

The Faculty supports the lowering of the Safety Net threshold, but has major concerns that the proposed 150% cap will limit access. We are concerned that the chosen cap level has not been adequately modelled specifically for its impact on radiation oncology; certainly the Department of Health has not been forthcoming with such data.

### The Faculty's responses to issues raised at the public hearing by the Department of Health

#### ***The majority of Safety Net and Extended Medicare Safety Net (EMSN) benefits are being utilised by patients in high socioeconomic areas.***

Medicare Statistics show that out-of-pocket costs for Radiotherapy and Therapeutic Nuclear Medicine has increased 18.3% per year over the last 5 years<sup>3</sup>.

<sup>1</sup> Barton M., Jacob S., Shafiq J., Wong K., Thompson S., Hanna T., Delaney G. National & International Benchmarks set following study of delivery of Radiotherapy Services: 'Review of Radiotherapy Optimal Utilisation Rates'. Collaboration for Cancer Outcomes Research and Evaluation (CCORE), Liverpool Hospital, Sydney, Australia, 2013: p6. Available from [www.inghaminstitute.org.au/sites/default/files/RTU%20Review%20Final%20Dec%202012%20v2%2019032013.pdf](http://www.inghaminstitute.org.au/sites/default/files/RTU%20Review%20Final%20Dec%202012%20v2%2019032013.pdf)

<sup>2</sup> Morgan, G. Why has Radiotherapy Utilisation not improved since 1999? Journal of Medical Imaging and Radiation Oncology. 2011 August; Volume 55 (Number 4) p347-350

<sup>3</sup> Department of Health Annual Medicare Statistics. Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics>

Many patients receiving radiation therapy for the treatment of cancer benefit from the Safety Net and EMSN, either directly or indirectly. These benefits are mixed between both low and high socioeconomic areas, and across private and public settings. Analysing only the patients that receive the benefits of this policy at a regional socioeconomic level does not appropriately understand the sector as a whole.

We are aware of business models that have flexibility based on the socioeconomic circumstances of its patient community. The perceived disparity in benefits across socioeconomic classes could be explained by one model that includes cross subsidisation between patients that do not have the ability to absorb the costs of what are generally considered to be underfunded services. A patient in a low socioeconomic area may be bulk billed for their radiation therapy treatment in a private practice setting. However, due to the underfunding of radiation oncology items in the Medicare Benefits Schedule (MBS), by bulk billing these patients the practice may be running at a loss, or experiencing a return that makes the practice an unviable investment option on its own.

It is important to note that this fee setting practice does not mean that patients who access the Safety Net and EMSN do not contribute to the cost of receiving the treatment. Given that the EMSN only covers 80% of the out-of-pocket cost, the remaining 20% is still generally covered by the patient (a figure that may be impacted by the greatest permissible gap) which can still be significant, given the cost of delivering underfunded radiation therapy treatments. Therefore, increased Safety Net and EMSN utilisation rates also indicate increased gap payments by patients.

A report released by the Australian Institute of Health and Welfare (AIHW) on 11 November 2015<sup>4</sup> highlighted the gains the sector has made in both accessibility and waiting times. The proposed changes to the Safety Net and EMSN have the ability to reverse the trends to the detriment of patients needed vital cancer treatment in a timely manner. If cross subsidisation models of payment are removed or reduced, the Faculty is concerned that private radiation therapy practices in some areas may be forced to close, resulting in a transfer of patients to the public sector – where there is little spare capacity. This would only serve to further exacerbate the current underutilisation problem.

Further to the findings of the AIHW report mentioned above, the report also highlighted the fact that patients who received radiation therapy were more likely to come from low socioeconomic classes. This seems to contradict the findings of the Department, or at least highlights the need for further investigation into the type of patients that receive radiation therapy treatment.

### ***More people will benefit from the New Safety Net***

As highlighted above, the Safety Net and EMSN benefits many radiation therapy patients, either directly or indirectly. These patients have potentially high out-of-pocket costs due to the current underfunding of radiation therapy in the MBS – given many of these items have not been reviewed for at least 25 years. Those patients who can absorb more of these costs do so, whilst patients who cannot may be bulk billed. The proposed New Safety Net is designed to transfer the savings made in areas such as the funding of radiation therapy, and provide more Australians with earlier access to Safety Net benefits through the implementation of a lower threshold.

The Department has stated that a net figure of around 53,000 patients will benefit from the reduced threshold. This net figure therefore implies that these patients would not breach the current higher threshold, indicating that their yearly medical bills are not as financially cumbersome as those receiving potentially life-saving radiation therapy treatment. The Faculty is of the view that capping the EMSN on underfunded services will simply transfer the funding of medical services from those with life threatening illnesses (e.g. cancer) to those who have smaller and potentially less severe medical needs.

<sup>4</sup> AIHW 2015. Radiotherapy in Australia: report on a pilot data collection 2013–14. Cat. no. HSE 167. Canberra: AIHW

### ***Expectation of a change in fee charging behaviour***

The Department has appeared to overlay economic assumptions from disciplines that do not reflect the similar fee setting requirements of the Radiation Oncology sector. Whilst some other medical specialists may have been able to adjust their fees following a capping of the MBS items, we do not believe that this is a long term solution to limit over charging of radiation therapy services.

The consistent underfunding of radiation therapy by the MBS is evidenced by the increasing level of funding for these services through the Medicare Safety Net. About 13% (\$49.9 million) of the total \$389.9 million in MBS funding for radiation oncology in 2014 was spent through the Safety Net<sup>5</sup> – particularly for modern treatment techniques such as stereotactic radiation therapy, as well as rotational and helical intensity modulated radiation therapy.

The main issue faced within Radiation Oncology is that the services currently listed on the MBS do not reflect the cost of providing the service. The Faculty supports steps taken to restrict unnecessary overcharging of patients, and is open to implementing a cap on services that are appropriately funded. However, until the MBS items are funded at a level that more appropriately reflects the cost of delivering radiation therapy, a reduction in funding through any means will be unlikely to be absorbed by the private sector. The result of this will be higher patient out-of-pocket costs, and the potential closing of unviable practices that will ultimately reduce access, increasing the burden on the public system.

The Faculty welcomes the establishment of the MBS Taskforce as a clinician-led initiative – to help improve the value derived from MBS expenditure, as well as revise and modernise the current MBS, to bring it in line with current best practice. We also support the MBS' vision of providing affordable universal access to best practice health services that represent value for the individual patient and the health system.

### ***Radiation Oncology is one of three professions that the EMSN provides the greatest total return***

High utilisation of the EMSN within Radiation Oncology is a result of the underfunding of its items listed on the MBS. Radiation therapy incurs a significant cost to deliver the treatment, and is often administered later on in the patient's treatment cycle when they have breached the Safety Net threshold from prior medical expenditures, such as diagnostic imaging and surgery or systemic cancer treatments. These factors combine to ensure that in order to provide access to what is still very much an underutilised service, the EMSN is vital in ensuring that cancer patients receive this potentially lifesaving treatment – which is involved in around 40% of cancer cures<sup>6</sup>.

### ***Creative billing behaviour has been observed by the Department***

At the hearing on 16 November 2015, the Department mentioned that they have been witness to the creative billing behaviours of practices. They highlighted an example of cataract surgery that resulted in an increased use of the anaesthetic item following the introduction of a cap on the surgical item. While this example is not relevant to radiation oncology, the Faculty does not and will not support creative billing practices. The Faculty wants a fair, modern and appropriate MBS – which is why we are eagerly supporting the MBS Review.

<sup>5</sup>Australian Government Department of Health Options Paper on Future Funding Options for the Australian Clinical Dosimetry Service, May 2015

<sup>6</sup>SBU, The Swedish Council on Technology Assessment in Health Care: radiotherapy for cancer, ACTA ONCOL 1996; 1:35

Radiation therapy is a cost effective treatment and its contribution to the fight against cancer is significant – it has been estimated to be involved in 40% of all cancer cures, compared to 49% of patients being cured by surgery and 11% through systemic treatments<sup>7</sup>.

But Radiation Oncology is a small medical specialty and very vulnerable to changes in the regulatory environment. The Faculty has very real concerns regarding the various reviews or proposed changes affecting radiation therapy services which are currently taking place simultaneously – i.e. the MBS Review, the audit of the Radiation Oncology Health Program Grants (ROHPG) Scheme, changes in health funding at the state level, as well as the proposed changes to the Medicare Safety Net.

Unless these reviews and proposed changes are considered together, the impact of uncoordinated changes (especially in the absence of evidence) could adversely affect patient access, thereby making the current underutilisation problem even worse – ultimately affecting health outcomes.

Please see the Appendix for past correspondence with the Health Minister and other Members of Parliament about this issue.

For more information, please contact the Faculty's Senior Executive Officer, Sonja Cronjé [REDACTED]  
[REDACTED]

Yours sincerely,

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**Dr Dion Forstner**  
**Dean, Faculty of Radiation Oncology**

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<sup>7</sup> SBU, The Swedish Council on Technology Assessment in Health Care: radiotherapy for cancer, ACTA ONCOL 1996; 1:35