GenesisCare

23 July, 2015

The Hon Sussan Ley MP
Minister for Health
PO Box 6022
Parliament House
CANBERRA ACT 2600

Dear Minister,

Thank you for your letter of 25 May 2015 regarding our concerns with the proposed new Medicare Safety Net. It is entirely consistent with your pledge, upon taking the position of Minister for Health, that you would consult with stakeholders and I thank you for being true to that commitment.

We wanted to take the opportunity to provide an update on our engagements with your office and the Department of Health. We also wanted to clarify a number of matters raised in your letter.

In your letter it was noted that the Safety Net was not developed as a mechanism to support patient access to new technology - a position that we understand. However, there are a number of "modern treatment techniques" that are expressly covered by the Medicare Benefits Schedule which are funded at a material discount to older and less targeted cancer treatment techniques. For example, Stereotactic radiosurgery (**SRS**) has an MBS item number (15600) which is currently funded at just 10% of international SRS reimbursement benchmarks and just ~12% of the MBS funding for a conventional long course treatment (see attached annexures A and B). By capping reimbursement for this heavily underfunded service, patient out-of-pocket costs will increase dramatically as will the perverse incentive to use a lower quality treatment (such as long-course whole brain radiotherapy). Similar perverse incentives will be exacerbated for Intensity Modulated Radiotherapy (**IMRT**) and Stereotactic Body Radiotherapy (**SBRT**) unless the funding for these techniques is at least brought in line with older less targeted treatment techniques.

We understand that the Government / MSAC requires evidence of superior clinical outcomes before additional funding can be provided for new techniques. However, for these treatment techniques there is no evidence that they are in any way inferior yet the current funding for these techniques is materially discounted. We further note that the basic radiobiology for these techniques suggests they are superior (i.e. less radiation to healthy tissue and more to the cancer) and they are increasingly featured in international and domestic treatment guidelines as the standard of care (e.g. the United States' National Comprehensive Cancer Network, NSW's EviQ).

Public Hospital radiotherapy services across Australia have already widely adopted these treatment techniques into standard care pathways, and I bring to your attention our work with the Western Australian Government at the Fiona Stanley Hospital. In this context, as suggested in your letter, our ability to limit access to these services is highly problematic. We don't want to be pressured into a position where the best or right standard of care is "rationed" based on affordability (i.e. our current approach on fees is to treat all patients irrespective of their ability to contribute to their care). Patients who can afford to pay effectively cross-subsidise those who can't. Further, a Medicare Benefits Schedule that funds widely adopted and better techniques at a discount to conventional treatments is flawed and inconsistent with the policy objectives focused on equity of access.

In response to the these clear disparities, we understand that MSAC has recommended the introduction of new IMRT item numbers which ensure that this technique is funded in line with 3D conformal treatment, even if it is

GenesisCare Pty Ltd Level 14, 44 Market Street Sydney NSW 2000
P +61 2 8236 3300 | F +61 2 8236 3399 | ACN 137 188 464

not funded at a premium as is the case in many other countries. We look forward to confirmation of this outcome by the Government.

We understand that the MBS review will provide an opportunity to address some of the above concerns (e.g. funding for SRS, SBRT treatments) and stand ready to support the review in any way we can. However, we understand that the outcomes of this review are unlikely to be implemented within the next 24 months creating a material timing disconnect between Capping of Safety Net benefits and addressing these underlying funding and access inequities. As a result, unless we can come to some arrangement to reduce the impact of the new safety net during the intervening period cancer patients will face material growth in out-of-pocket costs. It is an unfortunate but expected consequence that some services may have to be reduced or closed in many locations.

Currently 40% of all radiotherapy services in Australia are provided in the private sector. In many geographical locations (particularly regional areas) there is no public service within reasonable drive time. Therefore diverting these patients to a public service is not often realistic. Furthermore, in many locations the public sector does not have the capacity to take on additional patient loads and the direct impact of reducing access to care at privately operated services is to increase wait times at public services, further inconveniencing patients to the detriment of their health outcomes.

As suggested in your letter we continue to engage with the DoH on this issue and towards this end have met with Natasha Ryan on Wednesday 24 June. Subsequently we have met with Michael Ryan from DoH to discuss in detail potential solutions that would support sustainable implementation of the new Medicare Safety Net as referenced in your letter. At his invitation, we have submitted a recommendation that upholds both the Government's policy objectives and also ensure that cancer patients can get the right care at the right time. We understand and endorse the Government's policy objectives.

Given the new Safety Net is scheduled to be introduced in approximately five months it is critical for patients and those who will become victims of cancer that we address the current uncertainty regarding funding as soon as possible. We are consulting with patients now whose treatment will commence post the proposed introduction of the Simplified Medicare Safety Net (as they complete adjuvant surgery and chemotherapy). We have limited visibility of our reimbursement for their treatment or their potential out-of-pocket costs.

The policy uncertainty across several fronts is making ordinary course planning very difficult. It is also beginning to create practical difficulties at a patient and clinical level; a matter that I believe has been raised directly with you by the Cancer Council.

I recognise that the policy was first announced more than a year ago in the 2014 Federal Budget and that there have been numerous discussions which appear to be leading us toward a resolution. In that regard I want to acknowledge your preparedness to consult with the industry, including many advocacy groups, on this matter.

However, while we continue to engage with your office and the Department of Health constructively and proactively, we do hope you can soon create the policy clarity and allow cancer patients nationwide to immediately benefit.

Yours faithfully

Dan Collins
Managing Director

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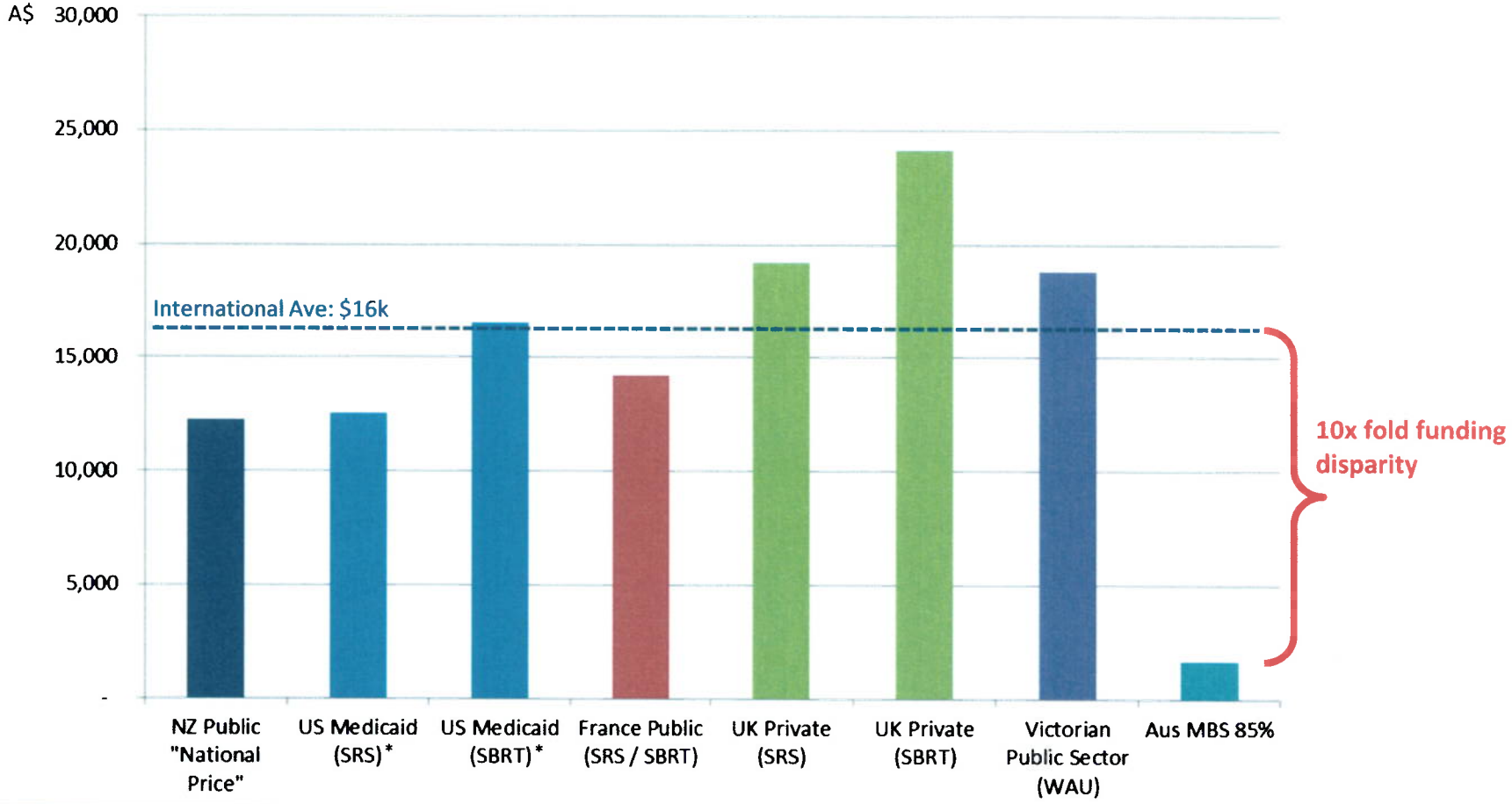
Annexure A: Current MBS funding does not necessarily reflect the cost of service provision making a benefit cap problematic

Case Study: Stereotactic Radiotherapy International Funding Benchmarks

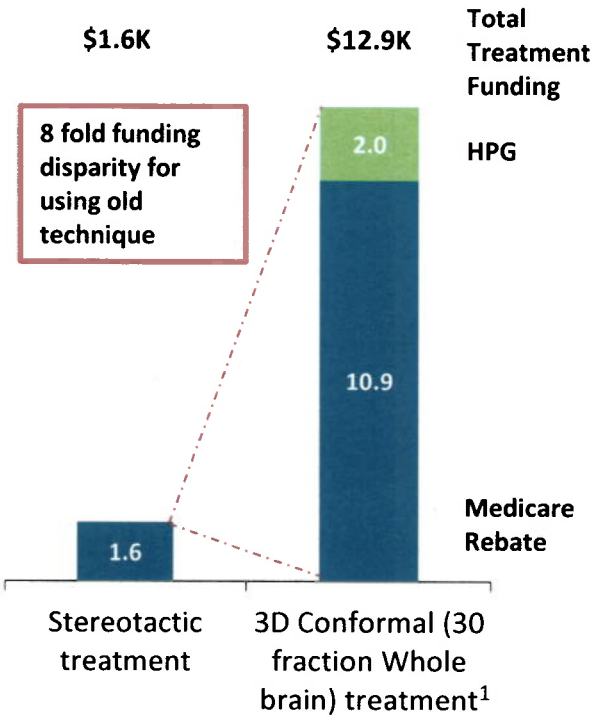


A 150% cap on safety net benefits will materially limit patient access to evidence based care

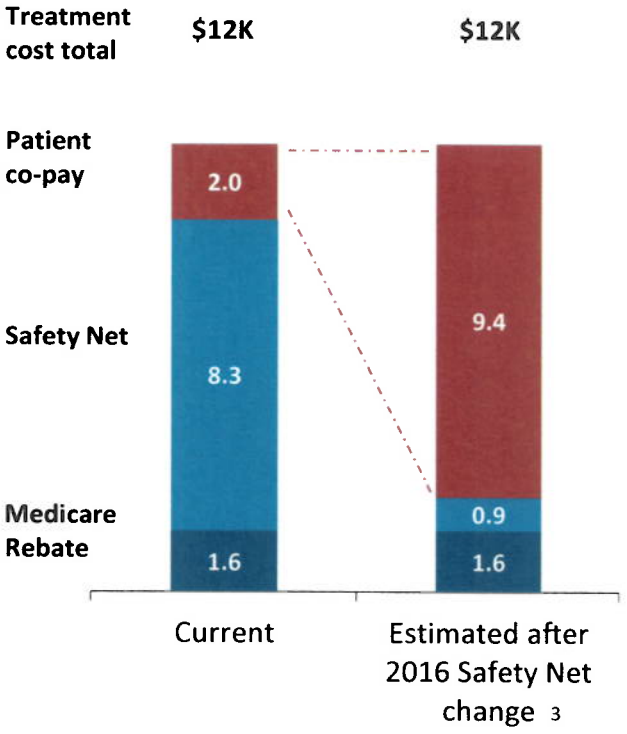
* Note: Excludes Professional fee for clinician

Annexure B: Capped reimbursement model with underfunding of modern treatment techniques will increase the perverse incentive to provide older, more expensive treatment modalities

Example brain radiotherapy – comparison of MBS85 rebate cover & HPG



Example Stereotactic Radiosurgery Patient[2]



Note:

1. Example patient receiving 3D conformal whole brain radiation therapy treatment
2. Example patient receiving modern stereotactic radiosurgery; assumes patient is through Safety Net at start of treatment, **note no HPG payable for stereotactic treatments**
3. Costs post 2016 Safety Net change estimated based on publically available information for proposed budget changes