Chapter 2

Key issues

2.1 Submitters to the inquiry expressed support for the Health Insurance Amendment (Extended Medicare Safety Net) Bill 2014 (Bill) as a cost saving measure.[1] The Australian Women's Health Network noted increases in the general Extended Medicare Safety Net (EMSN) threshold over the past nine years, with the current proposal to further raise 'the level at which higher income families are eligible to receive additional benefits for out-of-hospital services'.[2]

2.2 Some submitters did not support the proposal to increase the threshold[3] and the following key issues were examined during the inquiry:

- impact of the proposed measure on health and well-being;
- effect on equity of access to healthcare; and
- introduction of a short-term measure in the context of long-term reforms.

Impact of the proposed measure on health and well-being

2.3 Submitters argued that increasing the general EMSN threshold from $1,000 to $2,000 will affect healthcare affordability for consumers, with adverse implications for individuals' health and well-being.

2.4 The Consumers Health Forum of Australia (CHF) submitted that, contrary to the primary objective of the EMSN,[4] the proposed measure will require consumers to incur higher out-of-pocket healthcare costs before they are eligible for additional financial relief:

> Under the proposed arrangements, middle income families and individuals will need to incur $778.10 [sic] of additional out-of-pocket costs before they reach the new EMSN threshold.[5]

2.5 National Seniors Australia (National Seniors) observed that it may be difficult for consumers to find this extra money each year if they are on a 'tight' budget.

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1 Australian Council of Social Service, *Submission 2*, p. 3; Australasian Podiatry Council, *Submission 8*, p. 1.

2 *Submission 1*, p. 2.

3 Consumers Health Forum of Australia, *Submission 3*; Australian Medical Association, *Submission 5*, p. 1; Speech Pathology Australia, *Submission 6*, p. 2.

4 When the Extended Medicare Safety Net (EMSN) was introduced, its stated purpose was to protect all Australians from high out-of-pocket costs, particularly those people with complex health needs, families and other groups with high health care needs: see Centre for Health Economics, Research and Evaluation (2009), *Extended Medicare Safety Net: Review Report 2009*, p. 19, available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/Review_%20Extended_Medicare_Safety_Net/$File/ExtendedMedicareSafetyNetReview.pdf (accessed 21 May 2014).

5 *Submission 3*, p. 3.

Further, precisely how the measure will affect consumers is not known, as each case is different:

> [I]f you looked at it as a $35 out-of-pocket payment just for a [general practitioner] service and then you looked at what they might get back…they are going to lose quite a bit of money and have to put out a lot more money before they reach that safety net. It is the people on the margins who are going to be quite severely affected by this—people on restricted incomes, even if they are not people on an age pension. It is also going to hit people who have a chronic health condition or who need to go quite frequently to various healthcare providers—$700 is a lot of money when you have a tight budget that you have worked out for the year.[6]

2.6 Both National Seniors and the CHF expressed concern at the impact of higher out-of-pocket healthcare costs, resulting from the proposed measure.

2.7 The CHF submitted that Australian consumers already make a high direct contribution to healthcare costs (17% of total expenditure), with consumers spending on average more than $1,000 a year in out-of-pocket costs.[7] The committee heard that these costs are forcing consumers to make difficult decisions, including, for example, whether or not to: seek medical attention; fill prescriptions; and prioritise their own healthcare needs.[8]

2.8 National Seniors commented similarly in respect of older Australians, noting that out-of-pocket costs can rapidly escalate for various reasons. In addition to changes in healthcare needs, these reasons include: the gap between the Medicare rebate and fees charged by service providers; the lack of safety net coverage; the cap on specific items in the Medicare Benefits Schedule (MSB); the lack of private health insurance cover; and gap payments and/or annual limits on services covered by private health insurance.[9]

2.9 According to submitters, out-of-pocket healthcare costs particularly affect persons with chronic health conditions and high-level healthcare needs.[10] The CHF, for example, described the EMSN as a key support mechanism for these consumers:

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6 Ms Marie Skinner, Senior Policy Adviser, National Seniors Australia, *Committee Hansard*, 16 May 2014, p. 14.

7 *Submission 3*, p. 2. The Consumers Health Forum of Australia argued that vulnerable Australians are struggling with these high out-of-pocket healthcare costs.

8 Mr Adam Stankevicius, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, 16 May 2014, pp 1-2. See also: Consumers Health Forum of Australia, *Health Consumer Out-of-pockets Costs Survey: Results and Analysis*, May 2014, tabled 16 May 2014, pp 9-10; Australian Medical Association, *Submission 5*, p. 2, which stated that out-of-pocket medical expenses are a 'material element in cost-of-living pressures on households'.

9 *Submission 4*, pp 3-4. Also see: Speech Pathology Australia, *Submission 6*, p. 2.

10 National Seniors Australia, *Submission 4*, p. 2; Speech Pathology Australia, *Submission 6*, p. 2.

> There are a significant number of consumers experiencing chronic illness. Some of that is debilitating; some of it is manageable. They will obviously be the highest end users who are likely to reach the threshold quicker.[11]

2.10 Diabetes Australia provided one illustration of these concerns, submitting that diabetes, as 'a lifelong condition with complex care needs', requires constant management. Diabetes Australia stated that the EMSN assists people with diabetes to best manage their condition but increasing the general threshold will jeopardise this standard of care:

> For many, the safety net and its increased reimbursements is an important contribution to the significant expenses associated with managing their condition.
>
> ...
>
> Raising the safety net threshold and having people pay more may worsen access to the recommended cycle of care and the recommended [six] monthly monitoring.[12]

2.11 Diabetes Australia and the CHF noted that there are consumers with chronic health conditions and high-level healthcare needs to whom the concessional EMSN threshold does not apply. Diabetes Australia expressed concern about these consumers' capacity to access affordable healthcare, to manage their illness and prevent the development of further complications.[13] A representative from CHF stated: 'there are high users of the system who are not necessarily concessional users of the system'.[14]

2.12 In evidence, the CHF described concerns with the Medicare safety net, which, the representative argued, does not operate to the advantage of consumers with life-long, or later life, long-term illnesses:

> Obviously,…in a 12-month period, if you have those high-cost, acute, short time frame illnesses, you can [reach] the threshold quickly and those costs are reduced for the rest of that [calendar] year. If you have a chronic condition spread over 10 years or 20 years, you may never reach the threshold. Particularly if it goes up to $2,000, you may sit underneath that threshold and not actually be able, because of the nature of your illness, to get there, but you still experience those significant costs.[15]

Confirmation of family composition for EMSN purposes

2.13 One submitter – the Australian Women's Health Network (AWHN) – explicitly supported the proposal to allow the Chief Executive of Medicare to

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11 Mr Adam Stankevicius, *Committee Hansard*, 16 May 2014, p. 5. See also: Consumer Health Forum of Australia, *Submission 3*, p. 1.

12 *Submission 7*, pp 1-2.

13 *Submission 7*, p. 3.

14 Mr Adam Stankevicius, *Committee Hansard*, 16 May 2014, p. 2.

15 Mr Adam Stankevicius, *Committee Hansard*, 16 May 2014, p. 6. Also see: p. 2.

determine the manner in which families are contacted to confirm family composition for EMSN purposes. The AWHN endorsed the simplified process, which it argued would increase administrative efficiency for consumers and government.[16]

2.14 At the public hearing, witnesses commented briefly on the need for the Department of Human Services (Human Services) to communicate with consumers in an appropriate and timely manner. The Australian Council of Social Service (ACOSS) considered:

> [H]ouseholds need to be informed about what is going on. Particularly for low-income households, given that quite often the system is very hard to navigate and they are navigating a whole lot of the system,…ACOSS would support easy access to information, and people being notified about their entitlements when they are coming up so that they are able to access those entitlements[.][17]

2.15 In evidence, the representative from National Seniors indicated that older Australians prefer to receive hard copy information (via the post),[18] whereas the CHF representative highlighted that, for some Australians, electronic methods of communication may be the preferred medium:

> [W]ith the introduction of myGov and the translation of all the Medicare data over to that system, that there will be regular signals, probably text messages as well as emails, in terms of notification.[19]

Department response

2.16 The Department advised that the measure proposed in the Bill allows for flexibility in the way in which Human Services communicates with consumers. A departmental representative indicated that the proposal accommodates consumers' wishes, emphasising:

> There is no intent to reduce the information people get about where they are up to in terms of safety net entitlement or to ensure that they are aware that they are approaching the threshold. It is about, if you like, liberalising the way in which that communication occurs, to reflect technology changes and a range of other things.[20]

2.17 The officer confirmed that Human Services determines each consumer's preferred method of confirmation, which may or may not be in writing:[21]

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16 *Submission 1*, p. 2.

17 Ms Rebecca Vassarotti, Acting Deputy Chief Executive Officer, Australian Council of Social Service, *Committee Hansard*, 16 May 2014, p. 10.

18 Ms Marie Skinner, *Committee Hansard*, 16 May 2014, p. 13.

19 Mr Adam Stankevicius, *Committee Hansard*, 16 May 2014, p. 6.

20 Mr Richard Bartlett, First Assistant Secretary, Department of Health, *Committee Hansard*, 16 May 2014, p. 18.

21 Mr Richard Bartlett, *Committee Hansard*, 16 May 2014, pp 18-19.

> It is anticipated that with the current technology and systems that a letter will usually be sent to the nominated person's address as registered with [Human Services] for Medicare purposes. However, in future, this contact may be by email or SMS message if the person advises that this is their preferred form of interaction with [Human Services] for Medicare purposes.[22]

2.18 In addition, there are various sources of information, which consumers can readily access to obtain further detail about the EMSN. The primary source of information concerning coverage is a website called MBS Online.

2.19 An officer from the Department acknowledged that the MBS is not 'the easiest read' but the online service is available 24 hours a day, seven days a week.[23] In answer to a question on notice, the Department advised that 'there is no evidence that the use of MBSonline has been reduced because of technical issues'.[24]

Effect on equity of access to healthcare

2.20 Submitters considered that, by requiring consumers to incur higher out-of-pocket costs before qualifying for the EMSN benefit, the Bill impedes equitable access to healthcare.

2.21 The CHF, for example, referred to a recent research report,[25] which found:

- the impact of high out-of-pocket costs is most profound for the people who are most in need and vulnerable;
- consumers can face substantial unbudgeted out-of-pocket costs and co-payments;
- the EMSN does not adequately target consumers adversely affected by out-of-pocket costs to ensure they do not experience barriers to accessing care; and
- mechanisms to address inequity, such as healthcare cards, identify people on the basis of income level or carer status but do not accurately target those who have difficulty affording health care.[26]

2.22 The CHF expressed concern that the proposed change to the EMSN general threshold does not sufficiently consider, and may exacerbate, these problems. Its submission recommended that the Bill be considered in the context of the findings of the Community Affairs References Committee inquiry into Out-of-pocket costs in Australian healthcare.[27]

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22 Answer to Questions on Notice, received 27 May 2014, p. 2.

23 Mr Richard Bartlett, *Committee Hansard*, 16 May 2014, p. 20. The officer noted especially the operation of a telephone advice service by the Department of Human Services.

24 Answer to Questions on Notice, received 27 May 2014, p. 2.

25 Doggett, J., *Empty Pockets: Why Co-payments are not the solution*, Canberra, March 2014.

26 *Submission 3*, pp 2-3.

27 *Submission 3*, p. 3. See also: Mr Adam Stankevicius, *Committee Hansard*, 16 May 2014, p. 3.

2.23 The Australian Medical Association (AMA) acknowledged that the EMSN has helped consumers to access timely and affordable medical care, as well as preventing downstream costs to the healthcare system.[28] However, the AMA also raised concerns about the context of the Bill:

> In recent years, the EMSN has been systematically wound back with the introduction of caps on benefits and now this increase in the *extended general safety-net amount* – the upper threshold – proposed by the Bill.
>
> The Bill implements one of four 2014-15 Budget measures that together will significantly affect…the affordability of medical services for Australian families – measures that are designed to shift $1,852.9 [million] in costs for medical services from the government onto the chronically ill, the elderly, young families, and accident and trauma victims who all need medical care.[29]

2.24 The AMA contended that out-of-pocket costs are a material element in cost-of-living pressures:

> The larger they become, the more they undermine the equity of access to services under Medicare and, in turn, the more they undermine the lack of equity in health outcomes.[30]

Introduction of a short-term measure in the context of long-term reforms

2.25 On 13 May 2014, the Australian Government announced that the existing three safety nets for out-of-hospital services – the Original Medicare Safety Net, the EMSN and the Maximum (greatest) Permissible Gap – will be collapsed into one new Medicare Safety Net.[31]

2.26 The Department's Portfolio Budget Statements explained:

> This will simplify safety net arrangements and replace the original Medicare Safety Net and [EMSN] which are complex and difficult for both patients and practitioners to navigate and understand.
>
> The thresholds to access the new Medicare Safety Net will be lower than current thresholds, which will help more people and better ensure that Safety Net benefits are available to people who have serious medical

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28 *Submission 5*, p. 2. See also: Diabetes Australia, *Submission 7*, p. 3, which referred to the serious cost burden on Australian hospitals resulting from diabetes complications; Ms Marie Skinner, *Committee Hansard*, 16 May 2014, p. 15, who stated that, despite high out-of-pocket costs, many consumers endeavour to maintain their health and higher-level functioning so as to not burden the healthcare system.

29 *Submission 5*, p. 2 (italics in the original). The Australian Medical Association questioned the ultimate cost to consumers.

30 *Submission 5*, p. 2. See also: National Seniors Australia, *Submission 4*, p. 3, which stated that the proposed 60% increase in the general EMSN threshold is 'inequitable'.

31 Australian Government, *Budget 2014-15, Overview*, 13 May 2014, p. 13. The commencement date is erroneously stated as 1 July 2016, rather than 1 January 2016: see Australian Government, Department of Health Portfolio Budget Statements 2014-15, p. 83.

> conditions or have prolonged health care needs. The new thresholds will be $400 per year for individual and family concession card holders, $700 for [Family Tax Benefit (Part A)] families and non-concessional individuals and $1,000 for non-concessional families. The new Medicare Safety Net will introduce a cap on out-of-pocket costs that accumulate to a threshold and a cap on benefits received – both caps limit the Commonwealth's liability and contribute to restricting growth in Medicare.[32]

2.27 Witnesses commented on the interaction between the new Medicare Safety Net (due to commence on 1 January 2016) and the current proposal to increase the general EMSN threshold (effective 1 January 2015).[33] Representatives from the CHF, National Seniors and ACOSS considered that the multiplicity of thresholds, exclusions and capping arrangements will cause confusion among consumers.

2.28 The CHF commented:

> [The $2,000 general EMSN threshold] is proposed to come in on 1 January 2015. The one announced in the 2014-15 budget would come in on 1 January 2016 and bring it back down to $1,000. The carve-outs and the exclusions get more technical and more difficult to work through. The capping also gets more difficult to work through. It is not a simple matter of being just as easy as it is now to reach the threshold. With a new lower threshold, it will still be more difficult. Consumer confusion is one of the questions when you start carving stuff out, excluding it, putting caps on it and only having certain percentages that apply. You cannot necessarily plan your healthcare expenditure to get to the threshold, particularly if you are making decisions across financial years and you want to be able to ensure that you do get some kind of compensation…[I]f you have got a chronic illness and you are trying to manage that across the years, it makes it more difficult.[34]

2.29 National Seniors 'hoped' that the announced reforms had been considered in the formulation of the Bill,[35] while ACOSS suspected that this was not the case. An ACOSS representative stated that '[the Bill] absolutely does need to take into account some of the proposed changes'.[36]

Department response

2.30 A departmental representative acknowledged the measures announced in the 2014-15 Budget, allowing that 'the [EMSN] with the $2,000 upper threshold would be

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32 Australian Government, Department of Health Portfolio Budget Statements 2014-15, pp 83-84.

33 The Consumers Health Forum of Australia commented briefly on the interaction between the Bill and the proposed patient contribution (co-payment), which is due to commence on 1 July 2015, noting that the co-payment will not count toward the general EMSN threshold: see Mr Adam Stankevicius and Ms Donna Stephenson, Policy Director, Consumers Health Forum of Australia, *Committee Hansard*, 16 May 2014, p. 4.

34 Mr Adam Stankevicius, *Committee Hansard*, 16 May 2014, p. 3. See also p. 5.

35 Ms Marie Skinner, *Committee Hansard*, 16 May 2014, p. 13.

36 Ms Rebecca Vassarotti, *Committee Hansard*, 16 May 2014, p. 10.

in place for one calendar year, 2015'.[37] The Explanatory Memorandum states that the forecasted savings in the financial year ending 30 June 2015 will be $7.8 million, and for the financial year ending 30 June 2016, $48.5 million.[38]

2.31 An officer from the Department affirmed the Australian Government's position, as announced in the 2014-15 Budget, to direct all savings from the measures proposed in the Bill to the establishment of a new Medical Research Future Fund:

> From 1 January 2015, the Government will establish a Medical Research Future Fund (the Fund) that will grow to $20 billion–the largest of its kind in the world…Every dollar of estimated savings from health reforms in this Budget will be invested in the Fund until it reaches $20 billion [estimated by 2020].[39]

2.32 The departmental representative advised that the cost of implementing the Bill will be 'very small systems costs with [Human Services]',[40] meaning that the forecasted savings – as adjusted for 2015-16 – will largely stand.

2.33 The Department's representatives did not agree that amending the general EMSN threshold twice over a short space of time – from 1 January 2015 to 1 January 2016 – would confuse healthcare consumers:

> [C]hanging the threshold does not change at all what is in or what is out…the expenditure threshold at which benefits commence is all that is affected under this bill.[41]

2.34 Another officer added that the current system involves a level of complexity, which is unlikely to be significantly increased by the measure proposed in the Bill.[42] Further, communication materials relating to the EMSN will be updated and Human Services will contact certain consumers, to inform them of the changes.[43]

2.35 The departmental witness further advised that the proposed threshold amount was 'a decision of government in the budget context'.[44] Another officer explained that previous capping measures have failed to curb the growth in expenditure for the

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37 Mr David Learmonth, Deputy Secretary, Department of Health, *Committee Hansard*, 16 May 2014, p. 16.

38 Explanatory Memorandum, p. 2.

39 Budget Overview: see Australian Government, *Budget 2014-15, Overview*, 13 May 2014, p. 12. Also see: Mr David Learmonth, *Committee Hansard*, 16 May 2014, p. 21.

40 Mr Richard Bartlett, *Committee Hansard*, 16 May 2014, p. 21.

41 Mr David Learmonth, *Committee Hansard*, 16 May 2014, p. 16.

42 Mr Richard Bartlett, *Committee Hansard*, 16 May 2014, p. 17.

43 Answer to Questions on Notice, received 27 May 2014, p. 1.

44 Mr David Learmonth, *Committee Hansard*, 16 May 2014, p. 17.

Medicare safety net. Consequently, 'there is a logic in saying, "Let's look at how the safety net overall is working". The threshold is one way of dealing with that'.[45]

Conclusion

2.36 The primary purpose of the Bill is to increase the general threshold of the EMSN, with a view to ensuring its sustainability. In view of the measures announced in the 2014-15 Budget, this objective can only apply to the EMSN until 1 January 2016 when the new Medicare Safety Net will commence.

2.37 The committee accepts that the forecasted savings ($105.6 million over four years) will now be reduced but notes that there will be considerable savings achieved by the Bill – well in excess of its implementation costs – which will be redirected back into the health budget with the establishment of the Medical Research Future Fund.[46]

2.38 Participants in the inquiry expressed some concern that the reforms announced in the 2014-15 Budget, in conjunction with the Bill, will cause consumer confusion. While it may be too early to determine the precise level of confusion, the committee agrees that it will be necessary for the relevant departments to adequately explain the reforms to all stakeholders. Subject to the passage of the Bill, timely explanations will be most important throughout 2014 and 2015.

2.39 The committee recognises that consumers have preferred methods of communication and, according to the Department's evidence, the Bill proposes to facilitate this choice in consultation with consumers. The committee agrees that, in the absence of an expressed preference, the default position should be for Human Services to communicate in writing with consumers. Further, in the letter advising consumers of the changes resulting from the Bill, the committee suggests that consumers should be clearly advised of their right to nominate, at any time, a preferred method of communication, consistent with the stated objective of this measure (increased flexibility of communication).

2.40 The practical impact of raising the general EMSN threshold is difficult to quantify. The committee acknowledges that there will be some consumers affected by the temporary increase in the threshold, with the impact varying on a case-by-case basis. Further, the committee heard that persons with chronic illness do not necessarily reach even the current threshold.

2.41 Bearing in mind that the new Medicare Safety Net will shortly commence with new criteria and lower thresholds, and given the Community Affairs References Committee's more comprehensive inquiry into Out-of-pocket costs in Australian healthcare, the committee reserves its comment on the impact of the Bill in relation to the accessibility and affordability of healthcare.

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45 Mr Richard Bartlett, *Committee Hansard*, 16 May 2014, p. 17. The officer noted that, over a 12 month period commencing in 2012, there was a 70% increase in benefits paid for uncapped items.

46 Budget Overview: see Australian Government, *Budget 2014-15, Overview*, 13 May 2014, p. 12. Also see: Mr David Learmonth, *Committee Hansard*, 16 May 2014, p. 21.

2.42 On the basis of the above conclusions, the committee recommends as follows:

Recommendation 1

2.43 The committee recommends that the Department of Human Services be required, at the first opportunity, to notify persons likely to qualify for Extended Medicare Safety Net benefits of their right to nominate, at any time, a preferred method of communication with the department.

Recommendation 2

2.44 The committee recommends that the Bill be passed.

Senator Sue Boyce

Chair