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CENTRE FOR HEALTH ECONOMICS RESEARCH AND EVALUATION

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A: Public and provider views

Supporting document for the Extended Medicare Safety Net Review Report 2009

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A1 PUBLIC VIEWS ON THE EXTENDED MEDICARE SAFETY NET

This section describes the views of members of the public on the Extended Medicare Safety Net (EMSN). It looks at issues, concerns and complaints raised by members of the public or health care professionals in correspondence received by the Department of Health and Ageing. The Department of Health and Ageing provided the Centre for Health Economics Research and Evaluation (CHERE) with a sample of de-identified letters. The discussion of the contents of these letters is grouped under the following headings: coverage, thresholds for singles and families, and eligibility.

COVERAGE

The issues raised by correspondents under the heading 'coverage' were varied. Complaints were made about increasing gaps between the fees charged by both general practitioners (GPs) and specialists and the Medicare benefit available. The correspondents highlighted that all the medical services they sought were necessary, but provided in a way which made them ineligible for the EMSN (for example in-hospital). Similarly, the issue of 'medical services' being the only ones covered by the EMSN was also raised. Some expressed concern that the out-of-pocket (OOP) costs for non-Medicare services did not count towards the EMSN threshold. This issue is particularly pertinent for conditions where the diagnosis and/or treatment is often made by those allied health professionals whose services are not eligible for Medicare benefits.

Inconsistent billing practices between doctors (for example, some do not bulk bill at all, some only bulk bill for children) and inequity in terms of access to services (for example, out-of-hours GP services and obstetric services) were also highlighted.

A number of correspondents suggested that a means of capping medical fees be investigated. Such suggestions were made in light of their observations that, since the EMSN had been introduced, the gap between fees and the Medicare Benefit Schedule (MBS) fee had grown, that obstetrics administration fees had been raised at an exorbitant rate and that a better way of stopping a cost 'blow-out' might be to raise the MBS fee and/or cap the gap allowed to be charged by doctors. It was also mentioned that singles and families who do not qualify for the EMSN thresholds may be less likely to access necessary medical care if OOP costs continued to increase.

EMSN coverage of in vitro fertilisation (IVF) treatment was the subject of impassioned correspondence. Correspondents asked that this service continue to be covered by the EMSN as IVF would become unaffordable if singles and/or families had to bear the whole burden of OOP costs for IVF treatment.

The issue of defining in-hospital care was raised by members of the public who had been treated in a day stay facility (usually with eye surgery). Correspondents were confused by the fact that they were not aware of any admission procedures, were specifically advised that they did not need to be 'admitted' for such procedures and/or that the procedures took place in what they perceived to be the doctor's surgery. In the perception of these correspondents the services appeared to be out-of-hospital services, but were classified as ineligible for EMSN benefits (because they were in-hospital procedures).

THRESHOLDS FOR SINGLES AND FAMILIES

Correspondence on this issue centred on the perceived inequity of both families and singles being eligible for the same EMSN thresholds. Correspondents argued that the threshold for singles should be lowered because there are economies of scale in the cost of living for families.

The treatment of different members of a couple because they qualify for Commonwealth concession cards at different times (because they are different ages) was also raised. For example, there may be an age gap between one member of a couple receiving a Commonwealth concession card and the same status applying to the other member of the couple. In this case, correspondents perceived that a decision about whether to register as a couple when only one is eligible for the lower EMSN threshold is a difficult one. This issue illustrates that rules of the EMSN are difficult for many people to understand.

ELIGIBILITY

Four specific issues were raised by correspondents in relation to eligibility for the EMSN. First, the issue of the definition of a 'couple' was raised by people complaining about the ineligibility of same-sex couples to be classified as a couple. These correspondents listed the numerous ways in which same-sex relationships are recognised by law and in other jurisdictions and pointed to the inconsistency and discrimination of the definition as it applied to the EMSN. This issue has been rectified by recent changes to legislation.

A second definitional issue raised by correspondents was that of dependent children. Some pointed out that a person could be classified as dependent for the purposes of Centrelink payments (and therefore not eligible for certain payments), but classified as independent by Medicare for the purposes of the EMSN (and therefore their OOP costs are not eligible to count towards the family's threshold).

Third, the question of eligibility for the EMSN in relation to Family Tax Benefit Part A (FTB(A)) was a vexed issue for some. Although a government fact sheet explains that EMSN threshold eligibility will depend on the way FTB(A) is claimed, this was obviously a confusing issue, especially for those dealing with the birth of a child, maternity leave and uncertainty regarding annual income. An important issue raised was that of the EMSN being dealt with on a calendar year basis, compared to Centrelink dealing with such issues on the basis of a financial year.

Finally, and related to the above, the issue of threshold eligibility over one calendar year with the threshold starting again on 1 January of each new year was of particular sensitivity for correspondents who required treatment which spanned 2 calendar years. Letters pointed out that the timing of either the development of a condition such as cancer or the length of chemotherapy recommended by their doctor was not under their control. Moreover, they considered it very unfair that such an arbitrary cut-off point as 31 December made it necessary for them to be burdened with additional OOP costs in comparison to a person whose treatment could start and end within a single calendar year. Most correspondents also pointed out that they had already incurred significant OOP costs in relation to in-hospital treatment for their condition. It was mentioned that doctors also were not able to explain how the EMSN operated; for example, (mis)information was provided by a specialist indicating that, as the treatment required was continuous and for the same condition, re-qualification for the EMSN threshold would not be necessary.

A2 PROVIDER VIEWS ON THE EXTENDED MEDICARE SAFETY NET

As part of this review, we consulted representatives of the Australian Medical Association (AMA). A consultation took place on 25 February 2009 in Canberra. A list of representatives can be found at the end of this document.

Medical providers raised general issues about the operation of the EMSN and its relationship to other aspects of Medicare, as well as issues specific to a number of areas of practice specialisation. In this section, we will first cover general issues raised by AMA representatives, before turning to more specific aspects of the EMSN that impact on individual specialist groups.

General issues identified by AMA representatives

RISING COSTS AND MEDICARE

The AMA says that doctors are sensitive to the costs faced by patients and take their individual needs into account. As evidence for this, they point to the fact that 73.8% of GP consultations are bulk billed. Their view is that even with the EMSN the up-front costs faced by patients are often significant, which, in turn, underlines the importance of the EMSN. The AMA would like to see the government reaffirm its support for the EMSN.

The AMA says that, because MBS fees have not kept up with rising practice costs, Medicare is being used as a way of controlling costs in two ways:

- MBS fees have increased at rates below the Consumer Price Index (CPI), which means that the amount of public subsidy paid per Medicare service has fallen in real terms.
- Patients facing increasing OOP costs will limit their use of health care services, thereby limiting the growth of service use.

If this trend continues, the AMA argues, the EMSN will be operating as a type of second tier insurance scheme.

ACCESS AND AFFORDABILITY

The AMA is also of the opinion that the private health sector is crucial in taking pressure off the public health sector and the EMSN has made private services more affordable for a wider range of people, particularly those on lower incomes, and those living in rural and regional areas. This point was made about IVF services, obstetrics, and oncology services. We were also told that the EMSN has made psychiatric services more affordable for patients with chronic psychiatric conditions.

A COMPLEX SCHEME

The representatives we spoke to indicated that, in their experience, the mechanics of operation of the EMSN are difficult to understand. Doctors and their staff have difficulty in explaining how the scheme operates and in assisting patients in understanding how the scheme will affect them. Issues of eligibility, changes in family composition, and the re-commencement of the thresholds on 1 January each year were given as examples of the complexity of the scheme. These issues arose in a number of medical practices attempting to deal with the EMSN.

For example, several representatives commented that when an episode of care crossed over two calendar years the EMSN did not operate as intended.

These difficulties are compounded by the fact that many patients do not know that the EMSN exists—especially those using services where patients are not regular or routine users of the EMSN. For example, staff and many patients using cancer, IVF or obstetric services are now familiar with the EMSN. However, in general practice and other medical specialities, the details of the eligibility and threshold rules are poorly understood. This makes it hard for doctors to meet their obligation to provide informed financial consent to patients on OOP costs.

Specific issues raised by specialist groups

SPECIALIST OBSTETRIC AND GYNAECOLOGY SERVICES

Rising practice costs and constant Medicare benefits have meant fewer obstetric services are bulk billed and more services attract an OOP cost for patients. This specialty group says that without the EMSN patients would find it very difficult to access private obstetrics. According to the AMA, the EMSN has enhanced the affordability of private obstetrics.

A typical episode of care involves fourteen out-of-hospital sessions, three ultrasounds, blood tests, planning of care (item 16590), a post-natal visit and any emergency visits required. The AMA argues that, with the current baby boom, private hospitals play an important role in taking pressure off public hospitals.

Together with solutions which have been found for longstanding issues related to indemnity insurance, the availability of the EMSN has had an important impact on the obstetrics and gynaecology workforce. Whereas, until recently, it was difficult to attract local graduates to specialise in obstetrics and gynaecology, the changes outlined above have encouraged high quality applicants to apply for positions on the Royal Australian and New Zealand College of Specialist Obstetricians and Gynaecologists training program. There is now an excess of applicants over places.

The AMA recognises that, in reviewing the EMSN, there is a need to balance the benefits (for example reduced costs for patients) and unintended consequences (for example the danger that the scheme could be used as an uncapped subsidy for private practice) of the EMSN. The AMA also recognises that the incentives provided by the EMSN are to shift costs from in-hospital to out-of-hospital settings, and to structure OOP expenses so they can be covered by the EMSN.

In the lead-up to the introduction of the EMSN, the National Association of Specialist Obstetricians and Gynaecologists (NASOG) proposed mechanisms to redress these issues. For example, it suggested that the descriptions of item numbers be extended to recommend that two-thirds of charges be applied to the out-of-hospital component of charges and one-third applied to the in-hospital component. This was described as providing a 'soft cap' on charges via the consequent interaction with private health insurance gap cover. In preparing to implement this recommendation, NASOG and the AMA sent letters, including examples of how charges might be structured, to its members. See <www.ama.com.au/node/3890>. However, NASOG believes that this agreement was never fully implemented by providers, by the Department of Health and Ageing in the MBS item descriptor, or by Medicare Australia in responses to enquiries from individual providers seeking clarification of the use of the item number.

Patients in rural areas do not have the same level of access to the EMSN as others. This is due to there not being the same separation in rural areas between private and public sectors. Patients understand that the same small cohort of doctors will care for them whether or not they are admitted as private patients, so it is difficult for these specialists to charge significant gap payments. This contributes to the difficulties in recruiting and retaining a rural obstetric workforce. Without the EMSN, obstetrics patients in rural and regional Australia would, by and large, not be able to afford private practice where this option does exist. The EMSN is also important for rural patients who receive much of their care on a 'shared care' basis, as the OOP costs faced by GP patients are also significant; they argue that this type of practice should not be disadvantaged.

The AMA emphasises that, even though this area of medical practice is relatively familiar with the EMSN, there are still difficulties associated with explaining its operation to patients and assisting them to understand how it will affect them. For example, when a patient enquires about the costs of care, a practice will be able to explain the Medicare costs associated with an entire episode of care. But the practice is not able to provide details about what the EMSN will reimburse, because this depends on the individual patient's eligibility situation and time of year. The re-commencement of the threshold on 1 January each year is also difficult to deal with as it is not possible always to fit an episode of care into one year.

The AMA recommends that the review, in examining pre- and post-EMSN comparisons of fees and OOP costs, recognises that before the introduction of item 16590, patients were charged a booking fee that did not appear in statistics prepared by Medicare Australia. The AMA believes that a settling-in period of 12 to 18 months was necessary to achieve consistent billing practices for this item. Therefore, data from the first period of the operation of the EMSN should not be regarded as reliable.

IVF SERVICES

IVF and associated fertility services are an example of high-end technologies and programs which have experienced a high rate of growth due to increased demand. The increased demand can be explained by changing demographics and increased success rates. Australian programs import much of the equipment needed and face high practice costs. Since the public sector provides few fertility services, most people wanting access to such services seek care from the private sector.

According to the representative for this specialty group, the EMSN has allowed increased access and affordability for a wider range of people in terms of income and those living in rural and regional areas. The group argues that Australian IVF services are safe, effective and low cost, as evidenced by the demand from international patients. They also report that safety and effectiveness claims are supported by Australian Institute of Health and Welfare (AIHW) data.

Adequate funding, such as that provided by the EMSN, is needed so that best practice is achieved (for example, single embryo transfer). The group argues that services and patients should not be under financial pressure to transfer many embryos (as sometimes happens in the US) in the hope that one will become viable.

This specialty group says it is important to:

- take into account, when considering the benefits of the EMSN, the increased productivity of new members of the population produced by fertility services—the return to the country of a productive worker is five times the cost of IVF and related fertility services
- emphasise that the 1 January re-commencement of the threshold is not in the interests of patients as they are not able to control the length of an episode of care.

As in the case of obstetrics, pre-EMSN data on gaps is unavailable and unreliable as these extra charges were normally billed as a separate non-Medicare invoice.

SPECIALIST OPHTHALMOLOGY SERVICES

Overall, ophthalmology services do not generate high levels of reimbursement to patients via the EMSN. However, one item, an injection into the eye to treat macular degeneration, reached the 'top 40' EMSN items in 2007 as a result of the drug being included on the PBS. Much ophthalmology is delivered in the out-of-hospital setting so the EMSN is likely to be increasingly accessed as high technology procedures are developed and introduced.

In addition, the representative for this group says that there has been some media reporting around some ophthalmology services classified as out-of-hospital. An example of this is cataract surgery. While the media reported that a final decision had been made that these items could be treated as either an in-hospital or out-of-hospital procedure, the Royal Australian and New Zealand College of Ophthalmologists was always of the opinion that the items should only be performed in hospital.

Currently, patients' understanding of how the EMSN works, including eligibility and thresholds, is limited; AMA representatives recommend simplifying the processes.

PRIVATE PSYCHIATRIC SERVICES

The EMSN has been very helpful in allowing patients with chronic psychiatric conditions to budget and therefore afford adequate out-of-hospital care. The AMA representative stated that fewer psychiatric services are bulk billed because the Medicare benefit has not kept pace with the cost of specialist psychiatric practice.

In psychiatry, the MBS items most relevant are those used for intensive therapy (that is, MBS items 316 and 319—where 45 minutes sessions are used for either more than fifty sessions per year or more than one hundred and sixty sessions per year). Although a decreasing number of psychiatrists perform long-term intensive psychotherapy, many psychiatrists have a small number of patients with severe conditions needing weekly or twice weekly sessions to prevent suicide or hospitalisation. The AMA representative noted that the Royal Australian and New Zealand College of Psychiatrists has been involved in discussions with Medicare Australia about the issue of long-term intensive therapy and the great value of such services to the community. The College's own investigations have revealed that patients treated intensively were severely ill and were judged likely to require treatment for between 5 and 10 years.

One reason why private psychiatry is important in the area of long-term and/or intensive treatment is that only a very small number of public services are available to deal with such patients. In addition, some public sector organisations do not treat patients with chronic conditions, which may have also led to increased referrals of patients requiring intensive treatment to private practising psychiatrists.

Furthermore, it is feasible that state governments may respond to federal government initiatives that provide greater support to care provided in the out-of-hospital setting by assuming that such services will comprehensively cater for out-of-hospital care. This may lead to out-of-hospital care substituting for in-hospital care.

The AMA representative noted that the Royal Australian and New Zealand College of Psychiatrists supported the inclusion of Medicare items for use by psychologists which have been introduced under the Council of Australian Governments (COAG) Mental Health Reforms. In its opinion, the introduction of such items may have lead to additional identification of cases, including some severe cases, which need to be referred to and treated by private psychiatrists as they are beyond the scope of practice of psychologists and/or GPs. For many such patients, substitution of medical care with care from other health care professionals (for example psychologists) is not possible. For example, in cases where patients have associated co-morbidities (for example inflammatory bowel disease), the knowledge and expertise of a medical specialist is required to be able to differentiate between the medical and psychological somatized symptoms experienced by patients. In cases with significant treatment resistance, extended and intensive adjustment of medication, combined with psychotherapy, will be required to be delivered by a psychiatrist.

In the opinion of the AMA representative, there are a number of benefits associated with treating patients on an intensive out-of-hospital basis. First, it may avoid unnecessary hospitalisation; second, it often enables patients to continue working and maintain normal social relationships; third, intensive longer term treatment is associated with better and more stable long-term outcomes; and fourth, such intensive long-term treatment prevents other health care, welfare and community costs. In the out-of-hospital setting, the EMSN allows patients to be treated and followed up for an adequate length of time—without this, there is an increased likelihood of hospitalisation and consequent loss of contact with family and the community as well as a possible loss of income.

RADIATION ONCOLOGY SERVICES

Radiotherapy can be used to treat cancer as a single modality, as an adjunct to surgery, in combination with chemotherapy and in palliation. Sixty percent of radiotherapy is curative and 40% is palliative. A typical curative course involves a single dose 5 days a week for 5 to 7 weeks; a palliative typically involves five to ten treatments. Fifty per cent of people diagnosed with cancer should have radiotherapy; in Australia, currently, 42% of suitable patients are able to have radiotherapy; that is, there is still a level of unmet need.

According to the AMA representatives, 90% of radiotherapy is performed in the out-of-hospital setting and the remaining 10% is utilised in-hospital, frequently for palliation purposes.

Radiotherapy provision is characterised by high capital costs; a linear accelerator costs $3 million and needs to be replaced every 8 years; additional equipment costs $500,000 and one hundred and fifty staff are required for a facility with around ten machines. Since the last rise in the MBS fees, in a typical practice, salaries have increased by 30–60% and rents by 300%.

Currently, radiotherapy is provided by a mixture of private and public facilities. In recent years, services have been decentralised so that many more regional centres now have a radiotherapy facility than was the case 10 years ago. The AMA representative mentioned that, while in regional Victoria facilities may be either public or private, in New South Wales and South Australia regional facilities are mostly private. Overall, 30–40% of radiotherapy is provided in private facilities. Co-location is not sensible due to duplication costs and workforce shortages.

Public facilities tend to bulk bill patients more frequently than private clinics. However, it was highlighted that many private clinics will make special arrangements for patients who face difficulty paying fees. The advent of the EMSN has alleviated the burden of OOP costs for patients, allowing them to access private practices that are closer to home. Access is very important for rural patients as the long courses of treatment disrupt family life, including the ability to work for both patient and, often, their spouse. Dislocation of patients also increases OOP costs as they (and sometimes family) have to find additional accommodation. Waiting times have reduced considerably—from 16 weeks they have fallen to almost nil. Whether or not it is medically indicated, most patients do not want to wait once they have a diagnosis and know what treatment has been decided on.

Again, this speciality group considers the current EMSN system very complicated for patients to negotiate, and for doctors and other staff to explain to patients. For example, if the income of the patient is not known, it is not possible to predict the threshold. In addition, billing practices are complicated, which makes working out the probable reimbursement very difficult. The current economic climate reinforces the need for the EMSN as patients are less likely to be able to cope with OOP costs.

The re-commencement of the threshold on 1 January each year is inequitable as patients cannot control when they are diagnosed with cancer. The AMA representative recommends that this aspect of the EMSN be changed so that it covers a 'course of treatment'.

AMA representatives who attended consultation

The following representatives of the AMA and national associations of specialist medical practitioners were consulted regarding operational issues associated with the EMSN:

Australian Medical Association
Dr Rosanna Capolingua, President
Dr Gary Speck, Vice President
Mr Francis Sullivan, Secretary General
Ms Perry Sperling, Assistant Secretary General, Policy
Ms Belinda Highmore, Manager Medical Practice and eHealth

National Association of Specialist Obstetricians and Gynaecologists
Dr Andrew Pesce, Chair
Dr David Molloy
Dr Lucinda Pallis
Dr Christine Thevathasan

Australian Society of Ophthalmologists
Dr Russell Bach, President

Royal Australian and New Zealand College of Psychiatrists
Dr Bill Pring

Australian Association of Private Radiation Oncology Practices
Dr Michael Guiney