Treasury Review of Rules for Early Access to Superannuation

Input – Department of Health

Introduction
The Department of Health ('Health') is pleased to provide input to the review of rules governing the early release of superannuation benefits, given these have not changed substantially since 1997. As the Treasury is aware, in late 2017 Health commenced a stakeholder feedback process on the release of superannuation for medical treatment, and the role of third parties in such a process. A total of 15 submissions were received (summary at Attachment A).

The commentary and policy observations contained in this document are health-centric and intended to be fed into the broader macroeconomic plan for superannuation in Australia. This document therefore provides context on the Australian health system broadly, with a focus on the Medicare Benefits Schedule, public hospitals and private health insurance. Our understanding of the current model of access to superannuation for medical services is discussed with reference to stakeholder feedback and a selection of case studies.

Policy challenges with the current arrangements are identified from a health system perspective, and suggestions offered for policy and/or administrative improvements, ranging from minor to significant. Health will continue to assess the operation of the health system more broadly and the various levers available to achieve improved outcomes for patients within its control. Attachment B indicates reform and other priority work underway in Health, some of which may provide an opportunity to deliver complementary change, for example the work of the Ministerial Committee on Out of Pocket Costs.

We welcome the opportunity to further discuss the reflections in this paper with relevant officers. Natasha Ryan and s 22(1)(a) remain the Health leads on this work.

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Context – the Australian Health System
Total health care expenditure in Australia (excluding aged care) represented 9.7% of Gross Domestic Product (GDP) in 2014-15.[1] Medicare, the basis of Australia's universal health care system, covers many health care costs, providing for all eligible Australians to have: access to benefits (rebates) for privately rendered services listed on the Medicare Benefits Schedule (MBS); subsidised medicines listed on the Pharmaceutical Benefits Scheme (PBS); and free hospital services for public patients in public hospitals. Medicare is further supported by private health insurance policy.

At the 2017-18 Budget, the Government announced its commitment to guaranteeing Medicare and ensuring all Australians have access to a high-quality health system that is the best in the world. This commitment was supported by its Long Term National Health Plan (LTNHP) that is built on four key pillars:
1. Guaranteeing Medicare and access to medicines
2. Supporting our hospitals
3. Prioritising mental health, preventive health and sport, and
4. Investing in medical research.

[1] AIHW Health Expenditure Australia 2014-15

These reforms will go some way to addressing the fiscal sustainability pressures in the health system. Key specific reforms included:

- The establishment of a 'Medicare Guarantee Fund' from 1 July 2017 to secure the ongoing funding of the MBS and the PBS, guaranteeing Australians' access to these services and affordable medicines into the future. Proceeds from the Medicare Levy (less the contribution for the National Disability Insurance Scheme (NDIS)) will be paid into the Fund and topped up with a portion of personal income tax receipts to ensure it covers the combined costs of the MBS and PBS.
- As part of a series of compacts with Australia's general practitioners (GPs) and specialists, indexation of the Medicare rebates will be restored at an estimated cost of $1 billion over four years, starting with GP bulk-billing incentives from 1 July 2017, standard GP and specialist consultations from 1 July 2018, and specialist procedures and allied health services from 1 July 2019.
- A $957 million package to retain the bulk-billing incentives for pathology and diagnostic imaging, including blood tests, x-rays, scans and pap smears, along with reintroducing indexation for targeted diagnostic imaging services including mammography, fluoroscopy, computed tomography (CT) scans and interventional procedures, from 1 July 2020.
- Landmark agreements with Medicines Australia, the Pharmacy Guild and Generic and Biosimilar Medicines Association (GBMA), that are estimated to reduce the cost of medicines by $1.8 billion over five years and deliver an $825 million investment to strengthen patient outcomes and community pharmacy.
- An additional $2.8 billion in funding for public hospitals as well as providing $730 million to the Tasmanian government to secure the Mersey Community Hospital's future for the coming decade.
- Providing an additional $170 million for mental health support, treatment and research.
- $65.9 million released under the Medical Research Future Fund (MRFF) for eight research projects, including trialling new drugs, devices and services, clinical fellowships, and projects to address childhood obesity, with $1.4 billion to be allocated under the MRFF by 2020-21.

The MBS, public hospital funding and private health insurance are further examined with reference to early access to superannuation for medical services. In particular, Health contends that superannuation policy in respect of medical services should not be inconsistent with the rules of operation for these parts of the health system.

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The Medicare Benefits Schedule

The Medicare Benefits Schedule (MBS) is a listing of the Medicare services subsidised by the Australian Government and comprises the General Medical Services Table (GMST), the Diagnostic Imaging Services Table (DIST), the Pathology Services Table (PST) and 3C Determinations (the Chronic Disease Dental items for example). The *Health Insurance Act* (HIA) *1973* stipulates that Medicare benefits are payable for professional services that are considered clinically relevant and are listed on the MBS. A medical service is 'clinically relevant' if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Before a medical service can be listed on the MBS, the Medical Services Advisory Committee (MSAC), an independent expert committee, provides advice to the Minister for Health on the strength of the evidence relating to the comparative safety, clinical effectiveness and cost-effectiveness of the new medical service or technology. The first GMST in 1953 contained 880 items while the current MBS comprises approximately 5,700 items. Optometry, Cleft Lip and Palate (s3BA of the HIA), Oral and Maxillofacial services, and other allied health services (from 1 July 2004) are part of the GMST. The Dental Benefits Schedule ('Teen Dental' – July 2008 to

December 2013) and the Child Dental Benefits Schedule (from January 2014) are not part of Medicare.

The legislative basis for the regulations covering the various tables is contained in the HIA 1973. Subsection 10(2) of the HIA requires that:

- benefits for services to private patients in public or private hospitals or in approved day hospitals, and for hospital substitute services are paid at 75 per cent of the MBS fee;
- benefits for non-hospital (GP) attendances are paid at 100 per cent of the MBS fee; and
- benefits for other services are paid at 85 per cent of the MBS fee.

The MBS is ultimately an uncapped, demand driven fee-for-service program.

MBS benefits are not intended to fully cover the cost of doctors' charges. The Australian Government has no authority to set the fees charged by doctors nor can it require doctors to charge only the MBS fee for a particular service. It is observed that the freedom to charge out of pocket costs at times can lead to very large 'gaps' for patients. This in turn may contribute to the growth in applications for early release of superannuation to pay for medical services.

As further discussed at Attachment B, a clinician-led MBS Review Taskforce (the Taskforce) was established July 2015[2] to lead an accelerated program of reviews to align MBS funded services with contemporary clinical evidence and improve health outcomes for patients. The Taskforce has outlined five key reasons for making changes to the MBS, with the overarching objective of maximising the value obtained by the community and the health system, including:

- service obsolescence—where a service is universally inappropriate or unsafe;
- concern about 'low-value' care —where it may be desirable to better target services to patients who will benefit from the service;
- service frequency/intensity—where the evidence supports mandating the appropriate frequency of and/or intervals between tests and treatments;
- pricing failure—where the MBS fee structure has not kept pace with changes in practice or technology; and
- bundling/unbundling—where there is scope for improved efficiency and appropriateness through the combination or disaggregation of existing MBS items.

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Private Health Insurance

To encourage more people to take out private health insurance (PHI), the Australian Government introduced a PHI rebate on 1 January 1999 that provides a rebate to make health insurance more affordable. The rebate amount is based on the age of the oldest person covered by the policy and by the income of the individual or family depending upon circumstances. The rebate on the cost of PHI is either paid as a reduction in the amount of PHI premiums people pay to their insurer, or as a refundable tax offset when people lodge their tax return.

For those who do not have an appropriate level of PHI cover, and their income for Medicare levy surcharge (MLS) purposes is above a certain threshold, they will be required to pay the MLS. The rate of MLS paid depends upon the individual (or families) income for MLS purposes and applies unless the individual/family (and their dependents) are exempt from paying the Medicare levy.

PHI premiums make a significant contribution to the financing the Australian health system. As at 30 June 2017, about 11.3 million people are covered by hospital treatment policies in Australia (13.5 million are covered by general treatment cover only) and in 2017-18 insurers paid

[2] This was in addition to previous efforts including the MBS Quality Framework in 2010, and its successor, the Comprehensive Management Framework for the MBS, announced in the 2011-12 Budget.

approximately $19.6 billion in benefits ($14.6 billion in hospital treatment, $5.0 billion in general treatment) which funded around 4.6 million hospital episodes and 89.9 million general treatment services.[3]

A common theme contained in the stakeholder submissions is the lack of affordability and/or coverage of private health insurance and patients 'resorting' to accessing their superannuation to cover costs. Feedback suggested that patients access their superannuation for health care because:

- health insurance is not available for their treatment (for out of hospital services), or
- out of pocket costs are only partly covered (depending on the patient's level of insurance), or
- the patient has no insurance at all.

Public Hospitals and Management of Access to Services

The National Health Reform Agreement (the NHRA), signed by the Australian Government and states and territories in 2011, agrees the financial and governance arrangements for Australian public hospital services. The NHRA acknowledges that states and territories are the system managers of their respective hospital systems, and are responsible for the day-to-day administration of public hospital services within their jurisdictions. This includes the management of waiting lists for services such as bariatric surgery. Under the NHRA access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period, and must be offered free of charge.

As a general principle, any procedure performed in the private sector can also be performed in a public hospital. The differences between the two can relate to factors including waiting times and choice of doctor.

It has been observed throughout the consultation process that significant waiting lists in public hospitals may be contributing to patients desiring to access their superannuation to support themselves in obtaining the relevant services as a private patient. In relation to bariatric surgery in particular, many patients do not have private health insurance and although waiting list scheduling in the public system is reported to be a median wait of 81 days for primary procedures[4], in practice the actual wait can be much longer. Prior to getting onto an elective waiting list for bariatric surgery (i.e. the median 81 day wait), patients usually have to wait and then progress through a number of different pre-surgery bariatric programs. Anecdotal evidence suggests the actual waiting time for primary bariatric surgery can be up to seven years.

While the public hospital system will treat all emergency and lifesaving cases free of charge, for patients with very rare life threatening conditions requiring lifesaving or extending therapy not offered in public or private settings in Australia, patients can apply for financial assistance through the Medical Treatment Overseas Program. This program offers assistance to patients and their families to travel to renowned international institutions to receive effective therapies, often for cancer treatment, which are not offered in Australia.

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[3] Commonwealth of Australia (2017) Statistics: Private Health Insurance Quarterly Statistic - June 2017 (released 15 August 2017), Australian Prudential Regulation Authority.

[4] Australian Institute of Health and Welfare 2017. Weight loss surgery in Australia 2014–15: Australian hospital statistics. Cat. no. HSE 186. Canberra: AIHW.

The Superannuation Pathway for Medical Services
Early release of superannuation benefits on compassionate grounds is currently governed by Regulation 6.19A of the *Superannuation Industry (Supervision) Regulations 1994*. The Department of Human Services (DHS) is responsible for the administration of the policy and this responsibility will transfer to the Australian Taxation Office in 2018.

Individuals can apply for early release of superannuation benefits on compassionate grounds to meet expenses in respect of medical treatment for themselves or their dependant. When seeking early release for medical treatment, the individual must provide written evidence from at least two medical practitioners – one of whom must be a specialist – certifying that the treatment or medical transport:

- is necessary to treat a life threatening illness or injury; or alleviate acute or chronic pain; or alleviate an acute or chronic mental disturbance; and
- is not readily available to the individual or their dependant through the public health system.

DHS determines the maximum amount of benefits to be released early, taking account of the ground of release and the individual's financial capacity. There are no financial limits for early release of superannuation on compassionate grounds, except in the case of early release to prevent foreclosure on a mortgage.

Although individuals can apply for early release independently and at no cost, a number of third parties have emerged since 2014 that assist patients with their application for a fee – one of these third parties, SuperCare charges $680 for this service. Bariatric surgery and IVF, both of which are listed on the MBS, are examples of services for which SuperCare provide applicants with assistance in applying for early access to superannuation on compassionate grounds. The SuperCare website lists many partner specialists, some of whom fail to provide any information regarding their fees or arrangements with health insurers. During Health's consultation, nearly all medical stakeholders expressed concern about the involvement of third parties, particularly if there is financial gain. Health also holds concern about this model, particularly when there is a financial interest by the third party that may be encouraging inappropriate pathways for access to medical services.

In terms of the medical practitioner certifying the treatment meets the criteria, there is no legislative requirement that the medical practitioner be practising in the field of treatment for which the funds are being released. That is, eligibility for early release of superannuation is not necessarily focussed on the clinical effectiveness of the desired procedure, or the probability of achieving the desired outcome, but rather reliance on an assessment of an individuals' mental 'disturbance'.

As stated in the introduction, the MBS lists over 5,700 services and private health insurance benefits are generally only available to services listed on the MBS. Services listed on the MBS are Australian Government supported and are therefore considered to provide safe and effective treatment. Over the past 10 years or more, all new MBS services have had a thorough evidence assessment before they have been MBS listed. Services not funded under Medicare could be considered as experimental, unproven or not cost effective. Under the current policy, applicants can apply for the early release of their superannuation for a medical service that is not supported by evidence or considered to be an effective treatment by the Australian medical profession.

Where a patient has private health insurance, insurers are required to pay at least the remaining 25% of the MBS fee and hospital costs such as accommodation and theatre fees. In addition, insurers often have gap cover arrangements in place to eliminate or reduce the gap between the

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MBS fee and the fee charged by a doctor. Doctors can choose on a case-by-case basis whether to participate in this arrangement. For out of hospital services, assistance through Medicare safety nets to pay for out of pocket health services can be a significant contribution towards the cost of the health care. Generally, once an annual out of pocket cost threshold is reached, Medicare will pay 80% of all future out of pocket costs.

There are two scenarios where early access to superannuation funds are used to pay for in hospital treatment:

- The patient pays for the entire cost of the service (for patients with no private health insurance), or
- The patient pays for part of the cost of the service (for patients with private health insurance coverage). This generally involves paying the medical practitioner's fee above the Medicare rebate.

While Medicare funding covers a large portion of health care costs, particularly when safety net benefits are involved, unexpected or significant out of pocket costs may be beyond what some patients anticipate or can afford. Hence many patients seek to access their superannuation to pay their out of pocket costs.

<u>Bariatric Surgery and In Vitro Fertilisation (IVF)</u>

There are two commonly accessed MBS funded medical treatments which are paid or partly paid by patients accessing their superannuation. These services are bariatric surgery (provided in hospital) and in IVF (provided out of hospital). The two services share some common themes with the major similarity being that they have a very limited availability in the public setting. However, the mechanism for approval differs, with approvals for bariatric surgery usually being granted on the basis that the treatment is necessary to treat a life threatening illness or injury, and approvals for IVF being granted on the basis that the treatment will alleviate an acute or chronic mental disturbance. The following case studies outline further characteristics of funding avenues for bariatric surgery and IVF. There are also a smaller number of applications which the de-identified real-world case studies provided by the Department of Human Services at <u>Attachment C</u> highlight.

<u>Bariatric Surgery</u>

Comment:

Bariatric surgery is available in Australia's universal health system, either as a privately rendered MBS service, or as a public hospital service at no cost to patients. However, it is apparent there is limited access to public hospital funded bariatric surgery in some states. Health will continue to investigate MBS listed bariatric services, specifically issues around limited patient access due to limited public hospital availability, and any increasing trends in out-of-pocket costs. In practice, patients are accessing their superannuation to cover the full cost of privately rendered bariatric surgery (anecdotally around $20,000) or to pay the gap between the doctor's fee and the MBS rebate (can be >$5,000).

When comparing the number of approved early access to superannuation applications for bariatric surgery in the July to September 2016 quarter (1,858), with the number of MBS primary bariatric surgery services claimed in the same quarter (6,052), it can be approximated that 30% of MBS listed bariatric surgery services were paid for by patients accessing their superannuation on compassionate grounds.

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- Primary bariatric surgery procedures such as sleeve gastrectomy and adjustable gastric band are in-hospital procedures.
- The majority of bariatric surgeries performed in Australia are privately funded services. In 2014-15, only 4% of total bariatric procedures performed in Australia were funded by public hospitals.[5]
- Patient access to public hospital provided bariatric surgery can vary widely across states with roughly 300 public procedures performed in Victoria in 2014-15, compared with only 60 in New South Wales.[6]
- Public waiting lists can be significant for bariatric surgery, with anecdotal evidence suggesting up to seven years in some cases.
- For private MBS subsidised bariatric surgery, the most common procedure is sleeve gastrectomy (MBS item 31575):
    - the 75% Medicare benefit available for this item is $637.20.
    - in 2016-17, the average fee charged for this item was $2,342.70.
    - in 2016-17, the fee charged at the 95th percentile of providers was $6,000.
    - the average out-of-pocket cost for sleeve gastrectomy was $1,705.50, and this increased to $5,362.80 for providers charging at the 95th percentile.[7]
- Out-of-pocket costs can also accumulate for other MBS services such as anaesthetists and surgical assistants.
- For patients with private health insurance, at least the remaining 25% of the MBS fee will be covered ($212.39), and the remaining gap may reduce further or be eliminated, if a gap arrangement is in place.
- Private health insurance would also typically cover theatre fees and hospital accommodation costs.
- Bariatric surgery is commonly in a top premium tier for private health insurance, and typically requires a 12-month waiting period.
- If a patient had no private health insurance, they would have out-of-pocket costs resulting from doctors' fees, as well as hospital costs. Anecdotal evidence suggests this can amount to $20,000 (these costs are not collected by Health).
- In 2011, the Medical Services Advisory Committee (MSAC) considered the available evidence in relation to the MBS items available for bariatric surgery. MSAC agreed that bariatric surgery is a valuable intervention that is likely to be cost-effective but long-term data is lacking.

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[5] Australian Government Department of Health. 2018. Report to the Medical Services Advisory Committee on utilisation of MBS items 31569, 31572, 31575, 31578, 31581, 31584, 31587 and 31590: *An overview and review of the surgical treatment of obesity in Australia.* Canberra.
[6] Ibid
[7] Ibid

In Vitro Fertilisation (IVF)

Comment:
The Australian Government's MBS funding arrangements for IVF are some of the most generous in the world. However, despite generous rebates and the introduction of low cost providers to the market, patients can still be subject to out-of-pocket costs which can increase significantly when patients undertake multiple IVF cycles. Concerns regarding the potential provision of futile services to women past a certain age or number of cycles have been raised. The MBS items for IVF are currently being reviewed under the work of the MBS Review Taskforce.

- Over 99% of IVF treatment cycles in Australia are MBS funded (i.e. less than 1% are funded through public hospitals)[8].
- A patient undergoing IVF will typically receive benefits for a series of MBS items, i.e. for a patient undergoing a superovulated 'fresh' cycle, first in calendar year, the relevant items are: MBS items 13200 + 13209 (planning and management) + 13212 (oocyte retrieval) + 13215 (embryo transfer).
- The services required for IVF are predominantly performed out-of-hospital (78% in 2016-17)[9].
- In 2017, for an IVF superovulated 'fresh' cycle, first in calendar year:
    - the average benefits paid was $4,503.
    - the average fee charged was $7,067.
    - the fee charged at the 90th percentile of providers was $9,705.
    - The average out-of-pocket cost was $2,564, and this increased to $4,567 for providers charging at the 90th percentile.[10]
- As most of the services involved in IVF are out-of-hospital, private health insurance benefits generally do not apply. Most IVF services would however attract Medicare safety net benefits.
- In the last few years, a number of bulk-billing or low cost IVF providers have entered the market, providing alternative price options for patients.
- The MBS does not currently cover some services related to IVF, including pre-implantation genetic diagnosis and sex-selection.
- There are no eligibility restrictions on current MBS items, in terms of age or number of cycles. This makes Australia one of the most generous publicly funded arrangements in the world (New Zealand for example have an age limit of 40 years).
- Australian outcome based data suggests decreasing success rates in terms of a live birth, with increasing maternal age.[11]

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[8] Comparison of 2015 MBS data (Department of Human Services – Medicare Statistics) and data available in: Fitzgerald O, Harris K, Paul RC, Chambers GM 2017. Assisted reproductive technology in Australia and New Zealand 2015. Sydney: National Perinatal Epidemiology and Statistics Unit, the University of New South Wales Sydney
[9] Department of Health, unpublished data, based on date of processing, accessed 5 February 2018 (Cognos).
[10] Department of Health, unpublished data, based on date of service for claims processed to 31 January 2018 (ref Q21083), excludes incomplete episodes.
[11] Fitzgerald O, Harris K, Paul RC, Chambers GM 2017. Assisted reproductive technology in Australia and New Zealand 2015. Sydney: National Perinatal Epidemiology and Statistics Unit, the University of New South Wales Sydney

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Attachment A

Summary of Department of Health's Targeted Consultation

From 20 October 2017 to 22 December 2017, Health undertook a targeted consultation, with support from Treasury and DHS, to better understand the reasons for Australians accessing their superannuation early to pay for medical services. Stakeholders included key medical professional groups, consumer representative groups, private health insurers and third parties involved in applying for early access to superannuation on behalf of patients. Overall, the below themes can be drawn from the submissions. An overview of each individual submission can be found at Attachment A1.

1. **Overall policy**

- The majority of medical stakeholders support early access to superannuation for the purpose of paying for medical services and treatment, but in exceptional circumstances only.
- The majority of medical stakeholders expressed concern that current public health system funding is inadequate for treatments such as bariatric surgery, and that trends in superannuation access are likely a result of poor access in the public health system.
- A number of stakeholders felt that when there is a genuine need to treat life threatening injury, mental disturbance or acute/chronic pain, treatment should be accessible via the public system.
- Some medical stakeholders expressed concern about the consequences of depleting an individual's superannuation; that risks to financial security in depleting superannuation funds can impact directly on health and wellbeing.
- Some medical stakeholders thought that the trend to access superannuation might be result of private health insurers changing bariatric surgery to higher tiered insurance policies.

2. **Criteria for approval**

- The majority of medical stakeholders felt that the current threshold for approval was not too high. The majority of stakeholders agreed that bariatric surgery met the current criteria.
- The majority of medical stakeholders advised that the criteria for approval was vague, needed clarification, and needed to be strengthened. One stakeholder advised against being too restrictive or having criteria not based on evidence.

3. **Process for approval**

- A number of stakeholders advised that the process for approval needed to be stringent and transparent for patients.

4. **Role of medical practitioner**

- There were a number of suggestions from stakeholders regarding the role of medical practitioners in the approval process, including that at least one certifying doctor should be independent of the treatment being sought or any third party, i.e. at arm's length.

5. **Informed financial consent / financial advice**

- A number of stakeholders strongly supported informed financial consent processes, and that it should be made clear to patients that applications to the process are possible without a third party.
- A number of stakeholders also supported the requirement of independent financial advice so that patients understood the consequences of reducing their superannuation benefits.

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6. Third parties

- Nearly all stakeholders expressed concern about the involvement of third parties, particularly if there is financial gain. One stakeholder called for third parties to be disallowed from the process.

7. Fees

- No stakeholders had any evidence that doctors were increasing their fees on the basis of a patient using their superannuation, however, some suggested it was possible.

8. Other

- Some stakeholders expressed concern that some patients were not following through to surgery after superannuation funds were released, and suggested department follow up.
- One stakeholder suggested ‘health savings accounts’.
- One stakeholders suggested the amount of funds released should only include the ‘gap’, that is the amount between the Medicare benefit and the fee charged by the doctor. Approval is currently for the full amount.
- One stakeholder suggested that there should be no penalty for withdrawing superannuation for medical treatment. “It seems unjust that a person who needs to access super for mental health services is further penalised financially through having to pay 22% tax – a withdrawal for medical purposes should be exempt.”

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Summary of the 15 submissions received during the Department of Health's targeted consultation

Submission	Main themes / Any practical suggestions for change
1. Australian Medical Association	- Supportive of early access to superannuation, however, only on exceptional and compassionate grounds, such as treatment for end stage malignancy. - Strong view that superannuation should not be accessed to underwrite the "failings of health care financing". Approval trends suggest the current funding arrangements for bariatric surgery are inadequate. - IVF and bariatric surgery should be funded appropriately through the health care system, not superannuation. - Concern that risks to financial security in depleting superannuation funds can impact directly on health and wellbeing. - Bariatric – Concern that early access to super will further exacerbate social and economic hardship for those accessing it. Obesity is associated with socioeconomic disadvantage – also the population least likely to have PHI. However, it must be recognised that these patients may have no other option and that such treatments may improve quality and length of life. - IVF – AMA notes good access to IVF services through MBS and safety net arrangements. AMA concerned that early access to super to continue funding IVF has potential for downstream social and economic hardships that are only exacerbated by child rearing. - Third parties - Should only help on appropriate grounds, rather than using financial model that exploits most vulnerable. Commercial partnerships must be secondary to patient care. *Practical suggestions* - The government should explore 'health savings accounts' or similar to assist patients to save for out-of-pocket costs. - Process for approval: needs to be stringent. - Criteria for approval: needs to be clear, and this should be transparent to patients and doctors. - Role of practitioner: should not be to make decisions about whether early access is justified; rather role should be for clinical evaluations of patients and conditions. - Individuals must seek independent financial advice.
2. Obesity Surgery Society of Australia & New	- Early access to superannuation is appropriate for those patients who can't access bariatric surgery in the public health system, noting that currently less than 10% of surgery is performed in this setting. - Current criteria threshold: Obesity is recognised as a chronic disease. Therefore, appropriately indicated bariatric surgery

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Zealand	almost always meets the current criteria. - <u>Criteria for approval:</u> "life threatening" or "chronic illness / mental distress" are by their nature subjective and to some extent circumstantial and appropriately so. Restrictive, arbitrary definitions, without an evidence base, would potentially deny appropriate treatment. - <u>Third Parties:</u> ethical and regulatory concerns – do not encourage or support such arrangements and advise against them in all circumstances. - <u>Fees:</u> no evidence that surgeons adjust fees; surgeons would have set fees. *Practical suggestions* - There should be a department process to check that patients follow through with surgery – some patients access their super and then cancel surgery. Concern as surgeon has approved in good faith.
3. Australia & New Zealand Gastric & Oesophageal Surgery Association	- Suggests trend in accessing superannuation appears to correlate with the time many larger private health insurers moved to place bariatric surgery services in their higher tier products. The fact that patients are forced to take out the most expensive product limits many patient's ability to pay the requisite premium. - Issue amplified by relatively poor access to bariatric surgery in most state (public) health systems. Obesity is a disease that affects the socio-economically disadvantaged and potentially the demand for public service could be high. - <u>Current criteria threshold:</u> Bariatric surgery is a procedure that could be justified to genuinely be needed to treat a life threatening illness or chronic disease. - <u>Third parties:</u> commercial arrangements with doctors – there would be conflict of interest if doctor is financially gaining. Query the ethics of engaging third party providers to assist patients at cost of $900 which is paid by patient – the paperwork is not onerous *Practical suggestions* - <u>Criteria for approval:</u> "life threatening" threshold not too high, but it would be helpful for it to be clarified. Should "chronic illness" also be considered in addition to "chronic pain"? - <u>Informed financial consent</u> – important so that patients are aware that they have the choice of using a third party service, or completing the paperwork themselves.
4. Australian Society of Plastic Surgeons	- Overall recognise importance of superannuation savings, and supports working towards improving public health system, rather than encouraging people to fund their elective surgery from their super. Under current context, however: - <u>Current criteria threshold:</u> Cosmetic surgery is not supported by Medicare and should not be supported by accessing superannuation early. Abdominoplasty, breast reconstructions (and others) warrant early access to super as public waiting

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	lists long. Bariatric surgery should be eligible as patients would be healthier and participate in workforce etc. - Third parties: concern where medical provider has a financial relationship with a third party. Third parties potentially assisting patients to access for children's orthodontics, IVF etc. which don't meet criteria. *Practical suggestions* - Criteria for approval: Current threshold not too high, but needs to be adequately clarified by government. - Third parties: "We would support the government to disallow the involvement of a third party". There should be no cost for an individual to apply for their super and they should understand consequences, i.e. a reduction in their super balance on retirement (consent / financial advice).
5. Royal Australasian College of Surgeons	- In principle, RACS does not support early access to super for surgical procedures. Where there is genuine need to treat life threatening injury, mental disturbance or acute/chronic pain, RACS believes that this should be accessible via the public system. - Current criteria threshold: Threshold not too high – but the guidelines/criteria around existing processes for approving access could be better defined. - Third parties: RACS does not support third party involvement and notes the RACS Code of Conduct – doctors must disclose any financial involvement the surgeon may have with third parties. - Fees: may be possible to increase on basis of patient using super, however, no evidence. *Practical suggestions* - Criteria for approval: the guidelines/criteria around existing processes for approving access could be better defined.
6. General Surgeons Australia	- Early access to superannuation may be appropriate in exceptional circumstances when there are unacceptable waiting lists in public system. *Practical suggestions* - Approval process: needs to be tightly controlled. - Role of practitioner: patient should be seen by at least two doctors, one with no financial 'conflict of interest'. - Financial consent/advice: important that patient understands reduced funds in retirement versus increased quality of life of having procedure performed expeditiously. - Third parties: strong view that third parties taking money from patient's super to facilitate access to superannuation funds should not be endorsed. It was felt that doctors and patients should deal directly with super authorities as they do with

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	health funds.
7. Australian Orthopaedic Association	- Access may be appropriate when public waiting lists unreasonable. *Practical suggestions* - <u>Criteria for approval:</u> Criteria need to be robust and strictly but fairly applied as the process can rorted.
8. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists	- Some patients access super for infertility treatment – IVF, but also gynaecological surgery. - IVF access in public system should be reviewed. - Current threshold not too high. Access to super for IVF is in response to mental health disturbance – mental illness is higher in infertility patients. - Fees: accessing super should not affect fees charged. *Practical suggestions* - A mental health assessment should remain a condition of access. - Consideration should be given to an independent IVF doctor (who is not part of the clinic delivering the IVF treatment) to undertake an assessment of the application to access super. Arm's length of IVF provider or third party. - Third parties – there should be complete disclosure to the patient about any financial relationships, in particular any financial incentive
9. Fertility Society of Australia – IVF Directors	- IVF is a sufficiently good reason to access superannuation. Infertility genuine medical condition. - Mental disturbance criterion generally used for IVF – mental illness higher in infertility patients. - FSA present a case that adult children provide care for aged persons, which is good for society – restricting IVF may reduce this opportunity. - IVF, and occasionally gynaecological surgery, sparingly provided in public sector. - <u>Current threshold:</u> too high, would prefer severe illness rather than life threatening. - <u>Third parties</u>: could be in an ethically invidious position. - <u>Fees:</u> No evidence of doctors adjusting fees – extensive informed financial consent process. *Practical suggestions* - <u>Criteria for approval:</u> support access for severe infertility as a ground for compassionate release without need mental disturbance requirement.

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	- <u>Change amount of funds released to cover gap only, i.e. not MBS benefits:</u> Approval is currently for the full amount, rather than the gap (between fee charged and MBS benefit) – given multiplier effect we would have thought that the minimum requirement would be appropriate.
10. The Royal Australian & New Zealand College of Psychiatrists	- People with mental health issues without the means to meet out of pocket costs ought to be able to access quality health services in the public system, - Access may be appropriate if no other means to access/pay. - Current trend of increasing applications is a sign of overwhelmed system requiring people to access emergency funds for necessary health services. - False certifications: no evidence and existing safeguards appropriate. *Practical suggestions* - <u>Remove tax on withdrawal from super:</u> It seems unjust that a person who needs to access super for mental health services is further penalised financially through having to pay 22% tax – a withdrawal for medical purposes should be exempt. -
11. Obesity Australia	- Until there are appropriate and necessary obesity management services in the public system, patients will continue to need to access their super. - Concern re equity of access for bariatric surgery – as approx. 90% performed in private hospitals - Little opportunity for those without PHI to have bariatric surgery - Fee shouldn't change – sometimes it reduces. *Practical suggestions* - <u>Criteria for approval:</u> Criteria shouldn't just be for a treatment for life threatening or just alleviate chronic pain, but rather management should improve life, reduce risk and prevent future disease and ultimately prevent mortality. - <u>Role of practitioner:</u> Doctor that is certifying need for bariatric surgery should be independent of doctor and private hospital where surgery is being performed.
12. Access Australia	- Access to super would provide access to IVF services for consumers who would otherwise be unable to pay. - 'Mental disturbance' is vague, however, requiring psychiatric report implies an existing mental health disturbance. - Infertility patients are more accurately described as having a 'serious medical condition with life-long medical and social implications'.

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13. Defence Health	- Unaware of members accessing their super to fund medical procedures - Policies cover bariatric surgery and IVF and bariatric surgery claims increasing - Patients accessing super may affect the attractiveness of health insurance – this is inconsistent with the original intent of superannuation *Practical suggestions* - Consumers need appropriate and unbiased information regarding third parties to ensure fee transparency and informed consent - Potential for super funds to work with insurers to ensure patients receive value for money treatment through fee transparency mechanisms
14. Bupa	- Aware of members accessing their super to fund medical procedures - Policies cover bariatric surgery and IVF - Bariatric surgery claims increasing – 31% last financial year - Patients accessing super may result in a decline in private health insurance participation which will put a greater strain on the health system and increase premiums - Bupa hold concerns re third parties and access to super being driven by commercial entities - A lack of price transparency creates the risk that patients who access their super may be charged considerably more than insured patients because they miss out on non-gap and known-gap arrangements and because contract arrangements with private hospitals constrain the benefits paid - Overall concern is that patients accessing super for IVF and bariatric surgery are lacking visibility and regulation around fees charged, including by third parties. *Practical suggestions* - Price transparency should be mandated, including publishing a procedure cost guide for customers and all fees associated with the treatment (short an longer term financial impacts)
15. NIB	- NIB do not have visibility of the out of pocket costs incurred by patients above their policy benefits - Policies cover bariatric surgery and IVF and bariatric surgery claims increasing – 20% per year - NIB is of the view that ethical issues may arise with regard to relationships between practitioners and third parties who may have financial interests in signing applications to support the early access of super for patients - Patients accessing their super for medical purposes must comply with the guidelines and these must reflect that accessing

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	super for cosmetic reasons is not the intent of the policy - NIB note that a patient may access their super to undergo a procedure privately not because of public hospital wait times but because they do not meet the guidelines for treatment in the public system - Disinvestment in low value care may cause an increase in patients accessing their super for such procedures. *Practical suggestions* - NIB is supportive of the option of a 'health savings account' with favourable tax treatment to make health care costs easier in retirement as rising health care costs is inevitable - Any regulatory reform should consider how these relationships are managed, governed and disclosed to the patient - Occupational superannuation accounts should not be used as pseudo health savings accounts

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Attachment B

Health initiatives designed to pay for value, reduce fragmentation and increase transparency.

- Medicare Benefits Schedule Review
- Pharmaceutical Benefits Scheme – Health Technology Assessments
- Primary Health Networks
- Health Care Homes
- Patient Reported Outcome Measures
- Atlas of Health Care Variation
- My Health Record
- National Health Sector Productivity Measure
- Ministerial Committee on Out of Pocket costs

Medicare Benefits Schedule Review

The Health Technology Assessment (HTA) processes for approving Commonwealth funding of new medical procedures on the Medicare Benefits Schedule (MBS) is an example where the principle of 'paying for value' is applied in the economic evaluation of new services before an investment decision is made. The principle, however, is only applied upon listing on the MBS. Over time, the value of the item listed can come into question as service use moves away from the intended population or diagnostic thresholds, the costs of the delivering the procedure changes, and other relatively more valuable procedures become available (for example, a procedure may be considered 'low-value' care). Under the current Fee For Service (FFS) policy settings of the MBS, it is necessary that an appropriate disinvestment[12] process is in place to ensure that the amount currently funded for an MBS item reflects the contemporary value of the procedure.

To address the notion that the MBS is not necessarily maximising value for the government's investment, an expert, clinician-led MBS Review Taskforce (the Taskforce) was established July 2015[13] to lead an accelerated program of reviews to align MBS funded services with contemporary clinical evidence and improve health outcomes for patients. The Taskforce presented an interim report to the Minister for Health in January 2016 that outlined five key reasons for making changes to the MBS, with the overarching objective of maximising the value obtained by the community and the health system.

These reasons included:

- service obsolescence—where a service is universally inappropriate or unsafe;
- concern about 'low-value' care —where it may be desirable to better target services to patients who will benefit from the service;
- service frequency/intensity—where the evidence supports mandating the appropriate frequency of and/or intervals between tests and treatments;
- pricing failure—where the MBS fee structure has not kept pace with changes in practice or technology; and
- bundling/unbundling—where there is scope for improved efficiency and appropriateness through the combination or disaggregation of existing MBS items.

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[12] This term is used here to refer to amending (item scope, amount funded, etc.) and de-listing items.

[13] This was in addition to previous efforts including the MBS Quality Framework in 2010, and its successor, the Comprehensive Management Framework for the MBS, announced in the 2011-12 Budget.

Pharmaceutical Benefits Scheme – Health Technology Assessments
The Pharmaceutical Benefits Advisory Committee (PBAC) is an independent expert body appointed by the Australian Government to undertake assessments of new pharmaceuticals. The PBAC's HTA consideration of the clinical place, overall effectiveness, cost effectiveness and cost of a proposed medicine (compared with other medicines already listed on the PBS for the same/similar indications or compared to standard medical care), is an example of applying the principle of 'paying for value' to government investment decisions.

Unlike the MBS, items listed on the PBS are reviewed for cost-effectiveness (value) 24 months after listing and can be delisted or have their price reduced to what the PBAC considers as cost-effective. In addition to value of listed items being reassessed, it is common practice for pharmaceutical companies to educate prescribers on newly listed and more efficient drugs, and National Prescribing Service (NPS) MedicineWise also produce a regular publication called RADAR that goes out to all prescribers informing them about new listings or de-listings which helps ensure the use of high value medicines.

PBS statutory price reductions can also be considered as a further application of the 'paying for value' principle given that they result in further downward pressure on costs associated with achieving the outcomes of the drug. In accordance with division 3A of Part VII of the *National Health Act 1953*, a statutory price reduction of 16 per cent is applied to existing PBS-listed products when the first new brand or item that is bioequivalent or biosimilar, and has the same manner of administration as an existing brand or item, lists on the PBS. Medicines Australia and the Government have also recently signed a five-year agreement which will see innovative medicines reduce in price over 15 years.

The PBS Price Disclosure Program is another example of how the Australian Government is applying the principle of 'paying for value' when funding pharmaceuticals. The Price Disclosure Program commenced in 2007, was further refined in 2010 and 2014, and is now a routine part of maintaining PBS listings for medicines where more than one brand has been listed. The objective of the Price Disclosure Program is to ensure that PBS prices more closely reflect market prices and thus achieve greater value for government and consumers.

Primary Health Networks
On 1 July 2015, 31 Primary Health Networks (PHNs) were established across Australia to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care, in the right place, at the right time. PHNs are the central regional point for fund holding, planning and commissioning of a series of primary health care services, and integrating and coordinating the health system.

The six national priorities agreed by the Australian government for targeted work by PHNs are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, e-Health/digital health, and aged care. As described earlier in the paper, 'commissioning' describes a broad set of linked activities, including needs assessment, priority setting, planning, procurement through contracts, monitoring of service delivery, and review and evaluation.

Health Care Homes
A Health Care Home (HCH) is a general practice or Aboriginal Community Controlled Health Service (ACCHS) that coordinates care for patients with chronic and complex conditions. A patient who meets the eligibility requirements can choose to enrol in a HCH, and also choose a GP – usually the GP they have already been seeing – who knows them, their health conditions and priorities. This doctor leads a care team which will look after that patient. Together, a patient and

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their care team will then develop and follow a shared care plan which will: set health goals; develop strategies to help each patient better manage their conditions and improve their quality of life; and identify the best local providers who can meet each patient's needs.

Through the HCH model patients will be supported with better integrated care with access to coordinated medical, allied health and out-of-hospital services, regardless of whether they are provided by Medicare, state and local governments, the community sector or the multitude of other sources currently fragmenting the system. Through delivering more effective and better integrated care, HCHs have the potential to reduce demand on the acute care sector for chronically ill patients.

Patient Reported Outcome Measures
To identify gaps in outcome reporting, the OECD presented a member state survey of the national development of Patient Reported Experience and Patient Reported Outcome Measures (PREMs and PROMs) in December 2015. This work ultimately led to the OECD signing a letter of intent with the International Consortium for Health Outcome Measurement (ICHOM) at a Policy Forum and Ministerial meeting in Paris in January 2017. ICHOM is an international collaboration of key health sector stakeholders including physicians, outcomes researchers, health systems and patient advocates working to define global standard sets of PROMs for specific medical conditions. The letter of intent was entered into by the parties to facilitate collaboration on the collection, analysis and publishing of PROs for international comparison. The work will take place through an OECD program called PaRIS (Patient Reported Indicators Survey) which will work in close collaboration with ICHOM to globally standardise PRO collection in key disease areas, which will then be analysed and published to support patients, clinicians and policy makers.

Atlas of Health Care Variation
The Atlas of Health Care Variation (the Atlas) developed by the Commission, can be a valuable tool for empowering consumer choice and also for measuring quality of outcomes. The Atlas shows rates of use of health care (such as hospitalisations, prescriptions, surgical procedures) in geographical local areas across Australia. The rate is age and sex standardised to allow comparisons between populations with different age and sex structures. All rates are based on the patient's place of residence, not the location of the hospital or health service.

The Atlas presents a clear picture of substantial variation in health care use across Australia, in areas such as antibiotic prescribing, surgical, mental health and diagnostic services. Data from a range of national sources (such as the MBS, PBS, the National Hospital Morbidity Database [Admitted Patient Care National Minimum Data Set (APC NMDS)] and the AIHW National Perinatal Data Collection) is consolidated in the Atlas to explore variation across different health care settings.

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The first Atlas, released in November 2015, examined six clinical themes covering prescribing, diagnostic, medical and surgical interventions. The second Atlas, released in June 2017, went on to examine four clinical themes: chronic disease and infection – potentially preventable hospitalisations, cardiovascular, women's health and maternity, as well as surgical interventions. Whilst it is still only early days for the publication of the Atlas, it should help drive behavioural change among clinicians and practitioners, and see consumers with more information at their disposal to ask pertinent questions.

My Health Record
The Australian Government is committed to ensuring that the Australian health system becomes digitally enabled and connected, can continue to keep up with technological advances and meet the growing expectations of clinicians and individuals. As part of this commitment, the Australian

Government is building the My Health Record (MHR) system as an effective national shared electronic health record (EHR) system that can support a better connected health care sector, create a more efficient health care system and contribute to improved health outcomes.

The MHR system can improve the efficiency and effectiveness of the Australian health care system by:
- increasing the availability and quality of health information;
- reducing the number of adverse health events;
- reducing avoidable hospital admissions;
- reducing duplication of medical tests; and
- improving the coordination and quality of health care for patients.

National Health Sector Productivity Measure
The ABS has for some time measured the volume of health output based on a cost-weighted index of procedures. While this approach is best practice in national accounting, it does not take account of all sources of quality improvement. In particular the combination of innovation in procedures and drugs and the standard sources of market failure in health economics (such as the problem of asymmetric information) mean that it is difficult to draw inferences about health sector productivity based solely on the volume of procedures delivered.

The ABS is therefore looking to improve its measures of health sector productivity and has commenced a project that intends to replicate work undertaken by the UK Office of National Statistics (ONS) over the past decade. The 'outcome-based quality adjustment approach' used by the ONS relies on the following five separate measures of quality in calculating the quality adjusted health care estimates.
1. health gain
2. short term survival
3. waiting time
4. national patient survey of subjective satisfaction for hospital in-patients, mental health, primary care, outpatients and accident and emergency patients and
5. primary care outcomes

Ministerial Committee on Out of Pocket Costs
On 13 October 2017, the Minister for Health, the Hon Greg Hunt MP, announced a package of reforms to make private health insurance simpler and more affordable. An example of a reform to simplify private health insurance is requiring insurers to categorise products as gold/silver/bronze/basic and use standardised definitions for treatments to make it clear what is and isn't covered.

As part of this package, on 2 January 2018, the Minister for Health announced the Ministerial Advisory Committee on Out-of-Pocket Costs to be chaired by the Commonwealth Chief Medical Officer, Professor Brendan Murphy. The Committee will work together to develop best practice models to make information on out-of-pocket costs charged by doctors more transparent and to help consumers with private health insurance better understand out-of-pocket costs.

Better information about costs in the health care market may have an effect on the pressure some patients experience to pay for the cost of their health care using their superannuation.

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