The Senate

Community Affairs Legislation Committee

Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

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42nd Parliament

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Chapter 1

Introduction

Background

1.1 On 16 June 2009, the Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009 was referred to the Senate Community Affairs Legislation Committee for inquiry and report by 5 August. The committee combined this inquiry with consideration of the government's proposed legislation into the private health insurance rebate and the Medicare Levy Surcharge, though it is reporting separately on this bill.[1]

Purpose of the bills

1.2 The bill amends the *Health Insurance Act 1973* to enable the Minister for Health and Ageing to determine the maximum increase of benefit payable under the Extended Medicare Safety Net (EMSN) for specified Medicare Benefits Schedule (MBS) items. The EMSN was introduced in 2004 as part of the previous government's *Medicare Plus* reforms to provide individuals and families with an additional rebate for out of hospital Medicare services once an annual threshold of out of pocket costs is reached.

1.3 The Act provides that once an individual or a member of a registered family reaches the out of pocket EMSN threshold, they are entitled to a Medicare benefit equal to 80 per cent of their out of pocket costs for that claim for the rest of the calendar year. There is currently no limit on the amount of benefit payable under the EMSN. The Explanatory Memorandum (EM) notes that this has led some doctors to increase their fees with the knowledge that the majority of the cost will be funded by the Government once the person has reached the EMSN threshold. This also has implications for those people that have not qualified for the EMSN benefits.[2]

1.4 The amendments to the *Health Insurance Act* proposed by the bill would create a mechanism enabling the Minister to determine a cap on the EMSN benefit payable. The cap will be established in a legislative instrument which will be a disallowable instrument and therefore subject to parliamentary scrutiny. The EM explains that the cap on the EMSN benefit would apply to individual MBS items and, as is currently the case with EMSN benefits, be payable in addition to the standard

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1 The Fairer Private Health Insurance Incentives Bill 2009, the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009.

2 *Explanatory Memorandum*, p. 1.

Medicare rebate. Each person will be eligible to receive up to the EMSN benefit cap each time that they claim that item.[3]

Conduct of the inquiry

1.5 The committee received nine submissions relating to the bill, which are listed at Appendix 1 of this report. These submissions are also available at: http://www.aph.gov.au/Senate/committee/clac_ctte/fairer_private_health_09/submissions/sublist.htm

1.6 The committee held two public hearings. In Melbourne, on 9 July, it took evidence from the Fertility Society of Australia and a member of Access Australia's National Infertility Network. On 14 July in Canberra, the committee heard from the Department of Health and Ageing, the Australian Medical Association, the IVF Directors Group of Australia and New Zealand and the National Association of Specialist Obstetricians and Gynaecologists. The committee thanks these witnesses for their time and contribution.

Outline of the report

1.7 The report has three chapters. Chapter 2 explains the government's rationale for introducing the legislation and details the bill's provisions. It considers the findings of a report prepared for the Department of Health and Ageing (DoHA) by the Centre for Health Economics Research and Evaluation (CHERE) into the trends in EMSN expenditure. The chapter notes the government's position on the legislation and the support it has garnered from certain interest groups.

1.8 Chapter 3 looks at the criticisms of both the CHERE report and the bill as a whole. It notes the particular objections of medical groups representing obstetric and assisted reproductive technology services in response to claims that the increase in average fees for these services reflects an increase in doctors' incomes. The chapter presents the responses to these criticisms of both CHERE and the Department. On most counts, the committee finds these rejoinders convincing.

3 *Explanatory Memorandum*, p. 1.

Chapter 2

The need for, and basis of, the bill

2.1 The Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009 places a cap on the public subsidy for various out of hospital medical services under the Extended Medicare Safety Net (EMSN). It is based on evidence that the EMSN has contributed to fee inflation for these services.[1]

2.2 The bill is part of the government's broader efforts to 'reform and modernise' Australia's health system to ensure that 'tax dollars are used efficiently to provide better health outcomes'. By curbing what it terms 'excessive windfalls for medical specialists', the government intends that the measure will support the long-term sustainability of the Medicare safety net.[2]

The current Medicare safety nets

2.3 The current Medicare system has two safety nets whereby the government contributes to patients' out of pocket costs for Medicare services. The first net relates to the gap between the Medicare rebate for a service and its Medicare scheduled fee.[3] The rebate does not cover the full amount of the scheduled fee—hence the 'gap'—and doctors and specialists can, and do, charge more than the scheduled fee. When the gap amounts that a patient has paid within a calendar year exceed a specified dollar threshold (currently $383.90), Medicare pays 100 per cent of the gap that a patient is charged for subsequent medical services in that calendar year.[4]

2.4 The second Medicare safety net—the EMSN—was introduced in 2004 as part of the previous government's *Medicare Plus* package.[5] The EMSN provides individuals and families with a rebate to cover out of pocket costs for out of hospital Medicare services above a set annual threshold. When the threshold is reached, Medicare will pay 80 per cent of any future out of pocket costs for out of hospital

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1 See The Hon. Nicola Roxon, Second Reading Speech, House of Representatives Hansard, 15 June 2009, p. 5920.

2 The Hon. Nicola Roxon, 'A Sustainable Medicare Safety Net', *Media Release*, 12 May 2009.

3 The schedule fees are set by the federal government.

4 Dr Maurice Rickard, Bills Digest, No. 85, 2003–2004, *Parliamentary Library*, p. 8. http://www.aph.gov.au/library/pubs/bd/2003-04/04bd085.pdf

See also Department of Health and Ageing, *Submission 4*, p. 8.

5 The Health Legislation Amendment (Medicare) Act 2004 gave effect to these provisions. See Dr Maurice Rickard, Bills Digest No. 85, 2003–2004, *Parliamentary Library*, http://www.aph.gov.au/library/pubs/bd/2003-04/04bd085.pdf

services for the remainder of the calendar year. The policy excludes in-hospital services and medical services ineligible for Medicare benefits.

The rising cost of the EMSN

2.5 The EMSN was a policy response to the growing problem of high out of pocket costs for out of hospital services. In December 2003, the Minister for Health and Ageing, the Hon. Tony Abbott, introduced the EMSN legislation noting that 'the Health Insurance Commission will keep track of costs'.[6]

2.6 In February 2004, the Senate Select Committee on Medicare noted its report on the proposed *Medicare Plus* measures that 'a number of submissions' had highlighted the possibility of medical practitioners increasing their charges when they know the patient is close to or has reached the threshold for the relevant safety net.[7] The committee itself observed that the EMSN:

> …a system which includes uncapped out-of pocket benefits exhibits the potential for a relaxation in price discipline by doctors, thereby prices rise under the belief that an uncapped safety net guaranteed by government will be there to catch patients with high costs or needs.[8]

2.7 A year after the introduction of the EMSN, the scheme's expense led the government to increase the thresholds. In June 2005, Minister Abbott explained the reason for the government's decision:

> When first announced, the estimated cost of the extended safety net was just $440 million over the four years to 2006-07. After the safety net came into operation it became clear that these estimates needed to be revised. More people than expected qualified for safety net benefits, out-of-pocket medical expenses turned out to be considerably higher, and some specialties shifted charges onto Medicare out-of-hospital items so that their patients could claim safety net entitlements.[9]

2.8 Table 2.1 shows the lower and general thresholds of the EMSN from its introduction in March 2004 to its current levels. The thresholds were reset on 1 January 2006 and indexed to the Consumer Price Index.[10] The lower thresholds

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6 The Hon Tony Abbott, *House of Representatives Hansard*, 4 December 2003, p. 2. http://parlinfo/parlInfo/genpdf/chamber/hansardr/2003-12-04/0058/hansard_frag.pdf;fileType=application%2Fpdf (accessed 27 July 2009).

7 Senate Select Committee on Medicare, Second Report, *Medicare Plus: The future for Medicare?*, February 2004, p. 23.

8 Senate Select Committee on Medicare, Second Report, *Medicare Plus: The future for Medicare?*, February 2004, p. 27.

9 The Hon. Tony Abbott, *House of Representatives Hansard*, 23 June 2005, http://parlinfo/parlInfo/genpdf/chamber/hansardr/2005-06-23/0012/hansard_frag.pdf;fileType=application%2Fpdf

10 This decision was announced in the May 2005 federal budget.

relate to Commonwealth concession cardholders and those families who qualified for a Family Tax Benefit Part A payment. The general threshold is for all others.

Table 2.1: Extended Medicare Safety Net thresholds

Date	Lower threshold	General threshold
March 2004	$300	$700
January 2006	$500	$1000
June 2008	$555.70	$1111.60

Source: Centre for Health Economics Research and Evaluation (CHERE), *Extended Medicare Safety Net: Review report 2009*, A report by the Centre for Health Economics Research and Evaluation, Report prepared for the Department of Health and Ageing, University of Technology Sydney, Sydney, 2009, p. v.
The Hon. Nicola Roxon, 'A Sustainable Medicare Safety Net', *Media Release*, 12 May 2009.

2.9 Budget Paper No. 2 (2009–10) notes that expenditure on the EMSN has increased from $302.3 million in 2007 to $414.1 million in 2008. The items that the bill proposes to cap accounted for around 28 per cent of all expenditure on the EMSN in 2008 and the expenditure on these items has grown at an average rate of approximately 50 per cent per year for the past two years.[11] EMSN benefits paid for obstetrics and Assisted Reproductive Technology (ART) services, including IVF, accounted for more than 50 per cent of expenditure in 2008.[12] The majority of EMSN benefit goes to female patients of child bearing age.[13]

The CHERE report

2.10 Section 4 of the *Health Legislation Amendment (Medicare) Act 2004* requires the Minister to initiate an independent review of the 'operation, effectiveness and implications' of the Act. This review, initiated on 15 March 2007 by the former Health Minister, engaged the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology in Sydney. CHERE was selected following an open tender process.[14]

2.11 In the Second Reading Speech on the bill, the Minister for Health and Ageing, the Hon. Nicola Roxon, explained that 'in particular cases' the existing safety net was

11 Budget Measures 2009–10, http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2_expense-16.htm

12 Department of Health and Ageing, *Submission 4*, p. 4.

13 Department of Health and Ageing, *Submission 4*, p. 11.

14 Department of Health and Ageing, *Submission 4*, p. 18.

not meeting its purpose of protecting Australians for high out of pocket costs for out of hospital services.[15] The Minister tabled CHERE's independent review.[16]

2.12 The CHERE report observed that for services where an episode of care is likely to make patients qualify for EMSN benefits, 'providers feel fewer competitive market pressures to contain their fees'.[17] It noted that since the introduction of the EMSN in 2004, average fees have increased by around 4.2 per cent which is 'over and above' the rate of inflation. It estimated that the EMSN was responsible for 70 per cent of this increase, or a 2.9 per cent increase in fees per year.[18] Apart from the cost to the public purse from higher payments under the EMSN, this increase in fees means that 'some patients that do not qualify for EMSN benefits are now being charged higher average fees'.[19]

2.13 The CHERE report disaggregated the fee increases for particular services. It found that between 2003 and 2007, total Medicare benefits for obstetric services increased from $80.5 million to $199.5 million. Eighty-three per cent of this increase was attributable to the EMSN. Further, the in-hospital component of the benefit grew by only 8 per cent over the period compared to a 313 per cent increase in the out of hospital component. In the case of ART, government benefits increased from $55.5 million to $158.7 million, with 70 per cent of this increase attributable to the EMSN.[20]

2.14 The CHERE report also found that between 2003 and 2008, the fees charged by obstetricians for in-hospital services reduced by six per cent while the fees charged for out of hospital services increased by 267 per cent. Over the same period, fees charged for ART services for in-hospital services fell by nine per cent compared with an increase of 62 per cent for out of hospital ART services. The report observed that

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15 The Hon. Nicola Roxon, 'Second reading speech: Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009', *House of Representatives Hansard*, 28 May 2009, p. 8, (accessed 20 June 2009), p. 8 http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansardr%2F2009-05-28%2F0025%22

16 CHERE, *Extended Medicare Safety Net, Review report 2009*, A report by the Centre for Health Economics Research and Evaluation, 2009.

17 CHERE, *Extended Medicare Safety Net, Review report 2009*, A report by the Centre for Health Economics Research and Evaluation, 2009, p. 76.

18 CHERE, *Extended Medicare Safety Net, Review report 2009*, A report by the Centre for Health Economics Research and Evaluation, p. vi.

19 Department of Health and Ageing, *Submission 4*, p. 3.

20 CHERE, *Extended Medicare Safety Net, Review report 2009*, A report by the Centre for Health Economics Research and Evaluation, p. 49.

'the EMSN may have affected the incentives for doctors and patients to change from in-hospital to out-of-hospital service settings'.[21]

2.15 Tables 2.2 and 2.3 are reproduced from the Department of Health and Ageing's submission. They show the increase in Medicare benefits paid for obstetric and ART services, the increase in expenditure on these services and the number of services billed to Medicare.

Table 2.2: Obstetrics Services and Benefits under Medicare by calendar year*

	Medicare Benefits ($million)	% increase in benefits from previous year	Number of obstetrics services billed to Medicare	% increase in services from previous year	Number of MBS funded deliveries**	% increase in deliveries from previous year
Obstetrics						
2000	60.7		1,462,838		70,003	
2001	66.5	10%	1,473,021	1%	78,410	12%
2002	72.3	9%	1,473,434	0%	84,690	8%
2003	72.4	0%	1,422,727	-3%	82,268	-3%
2004	112.4	55%	1,432,633	1%	82,336	0%
2005	157.6	40%	1,414,410	-1%	84,925	3%
2006	171.9	9%	1,465,424	4%	86,132	1%
2007	198.6	16%	1,510,551	3%	89,645	4%
2008	227.9	15%	1,563,849	4%	91,313	2%

* Medicare data, date of processing.
**sum of services from items 16515-16522, includes delivery by any means, including caesarean sections.

Source: Department of Health and Ageing, Submission 4, p. 27.

Table 2.3: ART Services and Benefits under Medicare by calendar year

Calendar Year	Medicare Benefits ** ($ million)	% increase in expenditure from previous year	Services billed to Medicare	% increase in services from previous year
2000	39.3		131,004	
2001	43.3	10%	135,187	3%
2002	46.0	6%	139,086	3%
2003	50.0	9%	145,517	5%
2004 *	78.6	57%	159,181	9%
2005	108.4	38%	182,834	15%
2006	119.3	10%	195,557	7%
2007	158.9	33%	228,248	17%
2008	202.2	27%	252,813	11%

*Extended Medicare safety net introduced in March 2004.
**Note that this does not include other expenditure on ART such as PBS benefits.

Source: Department of Health and Ageing, Submission 4, p. 32.

21 CHERE, *Extended Medicare Safety Net, Review report 2009*, A report by the Centre for Health Economics Research and Evaluation, p. 62.

The bill

2.16 The bill restricts the rebate for costs incurred for out of hospital Medicare services. It introduces a cap on a range of items with 'excessive' fees. These items are:

- all obstetric services including some pregnancy related ultrasounds;
- all Assisted Reproductive Technology services;
- one type of cataract surgery;
- hair transplants for alopecia;
- one type of varicose vein surgery; and
- the injection of a therapeutic substance into an eye.[22]

For these items, the Government will only provide safety net benefits up to a certain amount. Specialists who increase their fees above these caps will increase patients' out of pocket costs.[23]

2.17 To this end, the bill amends the *Health Insurance Act 1973* (new section 10B) to allow the Minister for Health and Ageing to make determinations on the maximum benefit payable under the EMSN for certain items listed on the Medicare Benefits Schedule. New subsections 10ACA(7A) and 10ADA(8A) establish that the benefit payable under the EMSN is not to exceed the EMSN benefit cap. The caps will take effect from 1 January 2010.[24]

2.18 The capped items and the EMSN benefit cap will be established by legislative instrument and therefore subject to parliamentary scrutiny. The draft *Health Insurance (Extended Medicare Safety Net) Determination 2009* was tabled with the bill to demonstrate the operation of new section 10B. The Determination will establish those items which will have an EMSN benefit cap applied and the dollar amount of this cap. The Determination:

> …will allow the Government to be responsive to changes in circumstances which impact on the EMSN. It also means that small administrative changes that occur frequently, such as renumbering of MBS items and machinery of Government changes and annual indexation of EMSN benefit caps by CPI, can occur without adding to the legislative program of Parliament.[25]

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22 Budget 2009–2010, *Budget Paper No. 2*, http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2_expense-16.htm

23 See The Hon. Nicola Roxon, 'A Sustainable Medicare Safety Net', *Media Release*, 12 May 2009, (accessed 26 June 2009). http://www.health.gov.au/internet/budget/publishing.nsf/Content/4432C7FF32627D9DCA2575B2003D0AB0/$File/hmedia12.pdf

24 Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

25 Department of Health and Ageing, *Submission 4*, p. 20.

2.19 Table 2.4 shows that the bill's measures will provide savings of $257.9 million over four years. The projected savings in the first six months of the scheme (1 January 2010 to 30 June 2010) are $19.9 million, increasing to $62.4 million in the first full financial year of the revised scheme. For the year 2012–13, the projected savings are nearly $100 million.

Table 2.4: Savings from capping Extended Medicare Safety Net benefits

Expense	2008–09	2009–10	2010–11	2011–12	2012–13
Medicare Australia	-	1.6	0.4	0.2	0.1
Department of Health and Ageing	-	-21.5	-62.8	-79.4	-97.4
Total	-	-19.9	-62.4	-79.2	-97.3
Related capital ($m) Medicare Australia	-	0.9	-	-	-

Source: Budget Paper No. 2, 2008–09.

The government's position

2.20 In its submission to this inquiry, the Department of Health and Ageing noted that in 2007, only 8.5 per cent of families and less than one per cent of single people receive a benefit from the EMSN. It also noted that out of pocket costs for some Medicare services 'have now increased to the level seen before the introduction of the EMSN'.[26]

2.21 The government has largely attributed the increase in the EMSN to higher doctors' fees (as opposed to higher rates of claim). The Minister's Second Reading Speech cited the findings of the CHERE report which found that for some services, for every safety net dollar paid, 78 cents was spent on meeting higher doctors' fees. The Minister also cited the hike in out of hospital services costs (paragraph 2.9), adding:

> This indicates that some doctors are taking advantage of the safety net as their fees for out-of-hospital services have increased far in excess of the fees they are charging in-hospital patients.[27]
>
> …

26 Department of Health and Ageing, *Submission 4*, p. 3.

27 The Hon. Nicola Roxon, 'Second reading speech: Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009', *House of Representatives Hansard*, 28 May 2009, p. 8, (accessed 20 June 2009), http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansardr%2F2009-05-28%2F0025%22

> The unlimited nature of the benefits available through the safety net has led to some doctors taking advantage of the safety net to increase their fees with the knowledge that the majority of the cost will be funded by the government. This has had the effect of increasing the fees being charged to many people for some services, thus increasing the cost for those people who have not qualified for safety net benefits, as well as the cost to the government. The safety net benefit is for the patient. It is not intended to subsidise the fee increase of doctors.[28]

2.22 In terms of the anticipated cost for patients of the proposal to cap ART services, the Minister told Parliament that:

> The cost of IVF should not increase for most patients. On average, patients are charged around $6,000 per IVF cycle, yet there are some doctors charging in excess of $10,000 per cycle. Patients who see specialists who charge $6,000 or less for a typical IVF cycle will not be worse off under these changes.[29]

Support for the government's position

2.23 In some quarters, there has been strong support for the bill. Mr Robert Wells, Director of the Menzies Centre for Health Policy at the Australian National University, argued that the bill would address 'some of the outrageous rorts' under the EMSN 'without destroying the scheme'.[30] The Australian Healthcare and Hospitals Association similarly supported the government's efforts to 'reduce the opportunities for private providers to manipulate the system'.[31]

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28 The Hon. Nicola Roxon, 'Second reading speech: Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009', *House of Representatives Hansard*, 28 May 2009, pp. 8–9, (accessed 20 June 2009), http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansardr%2F2009-05-28%2F0025%22

29 The Hon. Nicola Roxon, Second Reading Speech, *House of Representatives Hansard*, 15 June 2009, p. 5922.

30 Australian National University, 'Policy expert welcomes health reform', *Media Release*, 13 May 2009.

31 Australian Healthcare and Hospitals Association, 'Mixed fortunes for hospitals', *News*, 13 May 2009.

2.24 In evidence to the committee, the Australian Nursing Federation noted that it had long been concerned with the incentives offered under the current EMSN. It argued that the absence of a limit on the amount of benefit payable is an enticement for doctors to increase their fees 'with the knowledge that the majority of the cost would be funded by the Government'. It added:

> The subsequently artificially inflated fee structure then has implications for those people who have not qualified for the EMSN benefit, as pointed out also in the Explanatory Memorandum. The ANF supports too, the setting of the EMSN in a legislative instrument so that it is subject to parliamentary scrutiny and thus gives greater assurance of protection of the public.[32]

32 Australian Nursing Federation, *Submission 7*, p. 7.

Chapter 3

Criticism of the bill and counterarguments

3.1 The committee received comment from several organisations that the modelling undertaken by the Centre for Health Economics Research and Evaluation (CHERE) was inadequate and incorrect, and that the bill's effect will be to put important medical procedures out of the financial reach of those who need them. This chapter discusses these claims and the counterarguments.

The Australian Medical Association's criticism of the CHERE report

3.2 In its submission to this inquiry, the Australian Medical Association (AMA) criticised various aspects of the CHERE report. It argued that the CHERE analysis:

- wrongly assumes that 2003 Medicare data on medical fees charged for certain Medicare Benefits Schedule items reflects the actual fees charged by doctors at that time. This data does not take account of fees charged for services not covered by, and therefore not reported to, Medicare in 2003;
- fails to understand the effect of compositional change on 'average fees'. The AMA emphasises that the rate of price increase reflects the changing mix of services being delivered annually, 'spurred by advances in technology'. Accordingly, the CHERE's analysis that the Extended Medicare Safety Net (EMSN) was directly responsible for a 2.9 per cent increase in fees per year 'is incorrect. The difference between government rebates and the real increase in the cost of delivering medical services over time was not taken into account;
- completely ignores practice costs and treats the increase in average fees as a proxy for doctors' incomes. The AMA stresses that the income doctors generate from providing professional medical services must service their practice costs, which may involve infrastructure costs in the case of assisted reproductive technology (ART); and
- wrongly uses Consumer Price Index (CPI) as a benchmark and implies that any increase in fees is 'excessive'. However, 'the rate of increase in CPI bears no relationship at all to the costs of medical practice'. The AMA suggested that the Average Wage Index would provide a more appropriate benchmark.[1]

3.3 The AMA's submission also queried the Government's modelling of the effect of the bill. In particular, it noted that the draft Ministerial determination provides EMSN caps for services that are provided in hospital: EMSN benefits are only payable for services rendered out of hospital.

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1 Australian Medical Association, *Submission 1*, p. 4.

3.4 The AMA recommended that the bill be amended to include a provision requiring the Minister to consult with the relevant medical groups about their fee structures and any proposal to introduce and/or change an EMSN cap before making determinations to impose EMSN caps on medical services.[2]

DoHA's response

3.5 In its submission, the Department of Health and Ageing (DoHA) responded to several of the AMA's criticisms. It acknowledged the Association's recommendation that the bill be amended to include the provision that the Minister should consult with the medical profession prior to the introduction of the EMSN benefit caps (paragraph 3.4). However, it responded:

> …section 17 of the LIA Act [*Legislative Instruments Act 2003*] sets out that before a rulemaker makes a legislative instrument, and particularly where the proposed instrument is likely to have a substantial impact on business or competition that appropriate consultation has taken place. The LIA Act also requires that the explanatory statement to the instrument includes a description of the consultation undertaken, or an explanation as to why no consultation has occurred.[3]

3.6 DoHA has also responded to the AMA's criticism that the government's modelling wrongly includes some EMSN benefits for in-hospital services (paragraph 3.3). It noted that for the few obstetric services that are provided out of hospital:

> EMSN benefit caps have been placed on these items to ensure that there is no perverse financial incentive to provide any services on an out-of-hospital basis. Although, these items will have EMSN benefit caps, the calculation of savings does not assume any savings from applying a cap to these items or the payment of EMSN benefits for these items, as current EMSN expenditure in this area is very small.[4]

3.7 Of the criticism that CHERE had wrongly used CPI data as a benchmark (paragraph 3.2), the Department gave the following response:

> CHERE used CPI to allow the fees charged data to be presented and analysed in 'real terms' that is, with the impact of inflation removed. This is standard practice when analysing data. CPI was not used as a benchmark for assessing whether the increases in the fees charged were reasonable as asserted by the AMA. The analysis did not examine whether the general increase in fees charged was acceptable or 'excessive' but rather whether the fees increased as a result of the EMSN.[5]

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2 Australian Medical Association, *Submission 1*, p. 4.

3 Department of Health and Ageing, *Submission 4*, p. 21.

4 Department of Health and Ageing, *Submission 4*, p. 31.

5 Department of Health and Ageing, *Submission 4*, p. 53.

CHERE's response

3.8 CHERE's EMSN Review Project Team has also provided the committee with a rejoinder to the AMA's criticisms of its review. Most fundamentally, the CHERE Team corrected the AMA's claim that the CHERE analysis compared 2003 and 2007 data. Rather, the analysis examined changes over the period 2000 to 2008 and in particular, whether the trend between these years differed from that between 2004 and 2008.

3.9 Of the AMA's criticism that CHERE's analysis fails to take into account services that are not covered by Medicare prior to the introduction of the EMSN, the CHERE Team responded:

> This is not true. The analysis incorporates our best estimate of such charges prior to 2004. It should be noted that we sought more information about these charges from the AMA, but we were informed that there were no data available.[6]

3.10 The CHERE Team described as 'incorrect' the AMA's claim that its analysis takes no account of the real increases in the cost of delivering services, and the shift to more complex services, over time. It noted that 'considerable effort' had gone into its analysis to establish a causal link between the EMSN and the observed changes in trends. To this end, the analysis:

- compared in-hospital with out of hospital results to control for general changes such as increases in the cost of practice; and
- included changes to the Medicare Benefits Schedule to control for new Medicare items, changes in Medicare benefits and greater complexity of patients.[7]

3.11 Finally, the CHERE Team also took issue with the AMA's claim that their analysis had used the CPI as a benchmark and that the fee increases above the rate of CPI were 'excessive'. While the CHERE analysis did use the CPI to adjust fees and benefits, 'we simply (and correctly) reported that the results obtained were over and above the rate of inflation'.[8]

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6 Centre for Health Economics Research and Evaluation, EMSN Review Project Team, *Submission 5*, p. 1.

7 Centre for Health Economics Research and Evaluation, EMSN Review Project Team, *Submission 5*, p. 1.

8 Centre for Health Economics Research and Evaluation, EMSN Review Project Team, *Submission 5*, p. 1.

Committee view

3.12 The committee believes that the Department and the CHERE EMSN Review Team have adequately addressed each of the AMA's criticisms of the EMSN Review's analysis.

Criticism of the bill

3.13 Among the various medical services for which the bill will cap public subsidy, there was most concern at the affordability and access for patients to assisted reproductive technology (ART) services. The committee took evidence from several organisations concerned that the proposal to cap the EMSN will make in vitro fertilisation (IVF) procedures unaffordable. Underpinning these concerns was an objection to the methodology and the findings of the CHERE report, and an insistence that the higher cost of IVF procedures principally reflects the higher level of investment in a higher quality service.

3.14 The committee has had recent experience with inquiries into ART and members of the committee have adopted a general line of argument that has been supportive of ART procedures. However, in this instance, where there is tension between supporting access to services and significant escalation of costs to the public purse, the committee recognises there is a significant dilemma.

The out of pocket costs for patients

3.15 The principal concern of witnesses representing IVF, obstetric and ophthalmological services is that the bill will financially disadvantage their patients. AccessAustralia, an independent charity established to raise community awareness about infertility issues, wrote in its submission that if the government's concern is excessive doctors' fees, the matter should be addresses with the doctors concerned. It claimed that the bill would penalise all families who need IVF, which will mean an increase in out-of-pocket costs of $3000 per cycle.[9]

3.16 Dr Molloy of the IVF Directors Group explained that while recent EMSN expenditure on obstetrics had not greatly inflated patient costs, the bill's proposals will cause financial disadvantage:

> My understanding of the data over the last two years is that the average safety net exposure, around Australia, as a fee for the management of a pregnancy for nine months is actually only $1,700…That fee had only risen by…about $100 a year over the time of the safety net. [T]he average working obstetrician looking after the average patient out there was only charging about $1,600 or $1,700. Now 100 per cent of these women are going to be worse off because the caps have been set so low in the obstetrics section of this document that most of them will not even get to

9 AccessAustralia, *Submission 8*, p. 1. See also Mrs Anne Hill, *Proof Committee Hansard*, 9 July 2009, p. 44.

> the threshold to access the safety net. So patients are going to be enormously disadvantaged, even if they are going to the 25 per cent cheapest obstetricians in this country.[10]

3.17 The AMA expressed also concern that the caps may be set at a level which does not trigger the safety net threshold. Dr Andrew Pesce, President of the AMA and the former President of the National Association of Specialist Obstetricians and Gynaecologists (NASOG), told the committee:

> You have to remember that the patients have to meet the first $1,100 per calendar year in out-of-pocket expenses before the safety net is triggered. Because the caps have been set at a fairly low level, I find it hard to see that a pregnancy in itself is going to trigger any safety net support. It is not just a question of capping; it is a question of capping in combination with a trigger threshold level for safety net support. If you are going to be, for all intents and purposes, removing safety net support, then you need to recognise either the patient is going to be a lot worse off or you have to make up for it in some other way.[11]

3.18 In its submission to this inquiry, the Australian Society of Ophthalmologists (ASO) noted that the Medicare reimbursement for cataract surgery as of November 2009 would be reduced from $623.70 to $307.20. It identified the 'most concerning effect' of this reduction as the 'economic viability of the delivery of eye care to rural and remote centres'. The ASO was unequivocal: if the Medicare rebate is cut by 50 per cent, the cost of cataract surgery will be 'beyond the reach' of the 'average Australian'.[12]

Doctors' fees

3.19 Chapter 2 noted that the CHERE report had found that between 2003 and 2008, the fees charged by obstetricians for in-hospital services reduced by six per cent while the fees charged for out of hospital services increased by 267 per cent. In the context of these data, the Minister explained that 'some specialists have taken advantage of this arrangement [the EMSN] to increase their fees and their incomes, unfortunately with no particular benefit to the patient'.[13]

3.20 Several witnesses took exception to this interpretation. Dr David Molloy, Deputy Chairman of the IVF Directors Group of Australia and New Zealand, explained that the out of hospital fee increases do not reflect doctors' higher incomes. He told the committee that:

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10 Dr David Molloy, *Proof Committee Hansard*, 14 July 2009, p. 39.

11 Dr Andrew Pesce, *Proof Committee Hansard*, 14 July 2009, p. 40.

12 Australian Society of Ophthalmologists, *Submission 6*, p. 3.

13 The Hon. Nicola Roxon, Second Reading Speech, *House of Representatives Hansard*, 15 June 2009, p. 5920.

> IVF item numbers are basically global item numbers: they cover 30 days provision of services for everything that the unit does—doctors' fees, ultrasound, pathology, scientific fees and psychological counselling are all bundled into one fee. Then, because of the Medicare Australia Act, it is put against a doctor's provider number. That is why, when the services increased due to increased access and affordability between 2004 and 2009, those top 10 doctors that the department presented to you had an increase against their names. It was basically the billing for a global item number, on behalf of their clinic, against their provider number. It has nothing to do with their personal incomes. It is like pathologists or radiologists billing on behalf of these quite large practices.[14]

3.21 Associate Professor Peter Illingworth from the Fertility Society of Australia also stressed that the figures the government has quoted on payments to doctors do not reflect a doctor's income. The fees contribute to various other costs besides income, including money:

> …for the staff to deliver the complex treatments, the scientific equipment, the culture media and the consumables used in the laboratories, as well as the ongoing research that is required to ensure that technology and results remain the best in the world. For every doctor who is involved in IVF, there are at least 10 scientists, nurses and counsellors delivering IVF care to patients. Around Australia, in excess of 2,000 employees work in the provision of IVF patient services.[15]

The booking fee

3.22 One explanation for the sharp increase in the average fee for ART services is that a booking fee for these services, which was in place prior to the EMSN, has been included in fees charged by Medicare.

3.23 Dr Pesce, President of the AMA and himself an obstetrician, gave the following context:

> ...before the safety net [the EMSN]…we just asked them [patients] to pay a booking fee. What that did was allow us to get our gap fee upfront, and we did not have to chase the patient later…The patient paid a single expense that allowed them to cover the gap, and I knew that I had no bad debts at the end of it.
>
> When the safety net came in, I had the opportunity to raise my antenatal visit charges to take advantage of that underpinning by the government. The patients knew that they were committed to this expense; the government had said that out-of-hospital services would be underpinned by a safety net…

14 Dr David Molloy, *Proof Committee Hansard*, 14 July 2009, pp. 32–33.

15 Associate Professor Peter Illingworth, *Proof Committee Hansard*, 9 July 2009, p. 37.

> In 12 months, all of a sudden Medicare expenditure on private obstetrics doubled because the previous amount, which had not been booked to Medicare, was now being booked to Medicare…It was not because doctors put up their fees; it was because they transferred an out-of-pocket expense of the patient to something that the government had said, 'Yes, it's available.' That has not been adequately explained or understood and, unfortunately, the statement that obstetricians' incomes have gone up by 267 per cent is just plain wrong.[16]

3.24 Associate Professor Illingworth also noted that in previous assessments of the cost of IVF services, DoHA had not factored in the booking fee that patients were required to pay prior to the introduction of the EMSN. He told the committee that part of the reason for the steep rise in IVF fees reported by the government was that these booking fees had not been taken into account.[17]

The drivers of higher costs for ART services

3.25 Apart from these process-based issues, the committee was also alerted to the higher technological and quality assurance costs associated with Australia's world class IVF services. Dr Hilary Joyce, the current President of NASOG argued that the CHERE report had failed to identify the value of benefits derived through better access to both obstetric and ART services as an offset to the cost of the EMSN. She noted that in ART, Australia has:

> …the world's best outcomes at about half the cost in the USA and less than two thirds of the cost in the UK. Far from our medical practitioners rorting the system they provide services at the top level of outcomes for costs below the OECD average.[18]

3.26 In terms of what has been driving the higher cost of ART services in Australia, Dr Joyce explained that:

> In both obstetric and fertility services, we have seen significant growth in the number of services being delivered. The number of children born has increased from a low of around 240,000 in 2003 to around 280,000 in 2008. The increase of 10 years in the average age of women and men having their first child since the middle of the last century, driven mainly by social and economic factors, is a driver of increased utilisation of fertility treatments.
>
> …
>
> Better access to services and treatment has certainly driven growth in costs to the Medicare safety net, but it has seen a corresponding improvement in

16 Dr Andrew Pesce, *Proof Committee Hansard*, 14 July 2009, pp. 38–39.

17 Associate Professor Peter Illingworth, *Proof Committee Hansard*, 9 July 2009, p. 38.

18 Dr Hilary Joyce, *Proof Committee Hansard*, 14 July 2009, p. 32.
See also Associate Professor Peter Illingworth, *Proof Committee Hansard*, 15 June 2009, p. 37.

> outcomes for those patients who have been unable to gain access to appropriate treatments before the implementation of the safety net.[19]

3.27 The committee is aware that a key yardstick of the quality of IVF services in Australia is the low rate of multiple embryo transfers. However, it does not believe that the maintenance of this high standard would be compromised by the proposed changes to the EMSN.

3.28 Dr Molloy told the committee that there are higher costs involved in ensuring single embryo transfers. He explained that following a 'major leap' in multiple IVF pregnancies in 2000–2001:

> We had to completely retool our laboratories for a completely different way of growing embryos…The retooling of the laboratories, which has actually continued over the last eight years, has been extremely expensive. We have also seen an expansion of services called ICSI, where we inject sperm into eggs, which has become the gold standard treatment. This ties up a scientist for most of an afternoon with a quarter-of-a-million-dollar microscope. Also, we have had to purchase more freezers and better storage facilities because we are freezing more embryos, as we have dropped down to only putting one embryo back under optimal circumstances. There has been a large flow-on of costs for that as well. The other point I would make is that our compliance costs with our auditing programs and quality assurance programs have dramatically increased. Units like…mine now have a full-time quality assurance officer, and most of us have employed such a person in perhaps the last three years. That is a high level position to oversee quality management in each unit. [20]

3.29 Associate Professor Illingworth told the committee that IVF clinics in Australia are required to comply with a level of regulation that is 'unparalleled in Australian medical practice'. He also noted that while Australia is a world leader in the transfer of one embryo at a time:

> We are very concerned that increased cost burdens for patients will cause increasing pressure to return to days of multiple embryo transfers, with adverse consequences for the health of the children and increased cost of natal care.[21]

DoHA's response to these concerns

3.30 The Department of Health and Ageing made a detailed submission to the committee following the public hearings, partly to address the various concerns raised with the bill. This section details those responses.

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19 Dr Peter Hilary Joyce, *Proof Committee Hansard*, 14 July 2009, p. 32.

20 Dr David Molloy, *Proof Committee Hansard*, 14 July 2009, p. 36.

21 Associate Professor Peter Illingworth, *Proof Committee Hansard*, 9 July 2009, p. 37.

Higher costs for ART services

3.31 On the broad question of what is driving higher costs for ART services, the Department acknowledged that MBS payments for services provided by ART doctors 'does not equal the personal income of these doctors and there are significant practice costs in providing ART'. However:

> …the payments do not include patient co-payments, payments for services that are not remunerated through the MBS, or facility and accommodation fees that are paid to the ART clinics for in-hospital ART services.[22]

3.32 DoHA's submission considered whether the higher fees charged by highest decile of ART doctors by Medicare derived income was due to an increase in the number of services they offered. Between 2005 and 2008, the average patient out of pocket cost for Medicare funded ART services by these doctors increased by $380 000 per doctor. DoHA observed that while there has been an increase in the number of ART services, 'there has been a similar increase in the number of ART doctors'. Accordingly, it concluded that the increase in fees per doctor is not a result of significant increases in the number of services provided by these doctors.[23]

3.33 DoHA questioned stakeholders' claims that higher ART costs reflected the burden of accreditation and compliance. It cited a study, published in 2009, which found 'no clear relationship' between the level of regulation of public funding of ART and the cost of an episode of ART treatment.[24]

3.34 The Department also doubted the credence of the AMA's claim that higher average ART fees reflect the fact that IVF is a uniquely capital and labour intensive area of health care. It gave the following explanation:

> There are numerous complex diagnostic and therapeutic procedures that are labour intensive and require regular large capital investments due to technological developments, yet ART is the only area to have systematically increased its fees to such a large extent.
>
> …
>
> Prima facie, costs of IVF clinics should be increasing consistently with other industries, particularly the medical sector. If they are not, then the IVF providers should be able to identify why not and provide information on these cost drivers. Most efficient big businesses should be able to identify their cost drivers and provide evidence on how these drivers have moved outside normal market increases. It is also interesting to note that IVF clinics are attracting the interest of large financial investment

22 Department of Health and Ageing, *Submission 4*, p. 33.

23 Department of Health and Ageing, *Submission 4*, p. 33.

24 Department of Health and Ageing, *Submission 4*, p. 34. The cited study is: Georgina M. Chambers, Elizabeth A. Sullivan, Osamu Ishihara, Michael G. Chapman, G. David Adamson, 'The economic impact of assisted reproductive technology: a review of selected developed countries', *Fertility and Sterility*, vol. 91(6), pp. 2281–2294, 2009.

> corporations including Macquarie Bank, ABN Amro and Quadrant Private Equity all of which have invested in IVF clinics since the introduction of the EMSN. This indicates that ART is a very profitable industry.[25]

3.35 Somewhat tersely, the Department concluded: 'what is unique about ART is not the intensity of capital and labour investment, but only the systematic increases in fees charged to patients to take advantage of the unlimited government subsidy'.[26]

Out of pocket costs for IVF patients

3.36 In similar vein, DoHA has argued that 'the majority of patents' needing ART procedures will not be affected by the legislation 'if doctors' charges remain at current levels'. It noted that a patient receiving a typical cycle of treatment billed at the median level of $6000 'should not be worse off'.[27] Chapter 2 (paragraph 2.22) noted the Minister's comments along the same lines. DoHA described as 'incorrect' the claim that patients' out of pocket costs would increase from $1000 to $3000 per cycle as a result of the Budget measure.

The booking fee

3.37 DoHA refuted the idea that the inclusion of the booking fee (used for ART services prior to the introduction of the EMSN) into the Medicare fees could be responsible for the sharp increase in either ART or obstetric average fees. In terms of obstetric services, DoHA claimed that 'it is reasonable to assume' that the majority of any booking fee charged by doctors for the out of hospital component of their service was largely included in their out of hospital fee by 2005.[28] In terms of ART services, DoHA argued that:

> …there has been an MBS funded item for the planning and management of an ART cycle since 1990 and in any case it is insufficient explanation for ongoing significant increases in the fees charged five years after the EMSN was introduced.[29]

3.38 On the issue of the booking fee for ART services prior to the introduction of the EMSN, and the claim that CHERE's analysis had failed to include this fee, the Department responded:

> …that CHERE conducted a sensitivity analysis for ART services to assess the impact of the EMSN on out-of-pocket costs including a booking fee. During consultations with the AMA and other professional groups, representatives from NASOG informed the consultants that there was a

25 Department of Health and Ageing, *Submission 4*, pp. 34–35.

26 Department of Health and Ageing, *Submission 4*, p. 35.

27 Department of Health and Ageing, *Submission 4*, p. 38.

28 Department of Health and Ageing, *Submission 4*, p. 25.

29 Department of Health and Ageing, *Submission 4*, p. 16.

> non-Medicare booking fee for ART services prior to the introduction of the EMSN. It should be noted that the Department does not have evidence of the existence of a booking fee being charged to ART patients prior to the EMSN. In fact there has been a Medicare item for the planning and management of an ART cycle (commonly referred to as the 'booking fee') in the MBS since 1990. The sensitivity analysis used two scenarios - where a booking fee was charged to ART patients prior to the EMSN and the situation where no booking fee was charged. Assuming that there was a booking fee, the EMSN Review report found that for every dollar spent on the EMSN for ART services, 31 cents went to higher fees and 69 cents went to reducing out-of pocket costs for patients. If it is assumed that there is no booking fee, the CHERE results indicated that for every EMSN dollar, 52 cents went to providers' fee and 48 cents went to assisting patients with their out-of-pocket costs.[30]

Committee view

3.39 The committee is satisfied that the Department has adequately addressed to the concerns put to the committee by various stakeholders. It recognises the difficulty of establishing a causal link between an increase in average fees for medical services and the range of factors that may have contributed to higher costs. Indeed, it is highly likely that recent increases in average fees for the services that the government proposes to cap are the result of several factors. However, the fact that the cost of ART and obstetric services has exceeded most other complex diagnostic and therapeutic procedures suggests that there is more at play than high labour, infrastructure, regulatory and quality control costs.

3.40 Above all, the committee emphasises that the current pattern of expenditure on the EMSN is unsustainable. Capping the most inflationary items will have the desired effect of curtailing public expenditure on the extended safety net. Whether it also restrains average fees for these services remains to be seen. The committee believes, however, that the introduction of a cap on the EMSN subsidy will send the right incentives to the medical profession: they must compete to provide a high quality of service as well as providing value for money for their patients. In terms of ART procedures, the committee reiterates DoHA's observation: if doctors do not hike their fees, patients seeking typical procedures should not be financially disadvantaged by the bill's measures.

Lack of consultation

3.41 In his evidence to the committee, Mr David Learmonth, Deputy Secretary of DoHA, told the committee that the Department had been in consultation with the AMA and NASOG about the safety net 'for some years'. He noted that as part of these discussions:

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30 Department of Health and Ageing, *Submission 4*, p. 38.

> There were, I think, undertakings for expressions of restraint, so at the end of the day some of the issues about fee increases and opportunities to take issue with their reasonableness, or their apparent unreasonableness, have existed in consultations over the last couple of years between us and the AMA and some of the craft groups.[31]

3.42 DoHA's submission noted that the Department 'is continuing to work with the profession' leading up to the implementation of the measure. It referred to 'currently working with' the ART profession including members of the IVF Directors Group and future work with obstetrician groups on the new items for obstetric services.[32]

3.43 However, the committee is aware that peak professional groups are frustrated with what they view as DoHA's inadequate consultation in the lead up to the bill's introduction. Dr Joyce of NASOG told the committee that the AMA had had a meeting with representatives of CHERE in March of this year. During the meeting, CHERE representatives sought input from 'specialty representatives' and 'undertook to meet with them to review progress in the report prior to submission to the government of the final report'. Dr Joyce also noted that CHERE had indicated that the report could not be completed until July 2009.[33]

3.44 Dr Pesce corroborated this evidence, with reference to a meeting between the AMA and DoHA officials in February this year. He gave the committee a sketch of the discussion. DoHA officials told the AMA:

> 'This is going to take a long time. It's very complex. We don't anticipate we're going to publish the report before July.' We asked: 'When is this going to be ready? Is it going to be used in the budget process?'…They said, 'There is no way this will be done before July.' We said: 'To avoid us having to go out and potentially criticise anything that we see has been done incorrectly, would you give us the opportunity to have a look at your draft report? We can't tell you what to write, but at least give us a chance to have input into what we see you're doing and give you some feedback.' They said, 'Yes, we'll be able to do that.' Then all of a sudden we were overtaken by events, the report was published in time for the budget and we had not been consulted.[34]

3.45 Other organisations also expressed their disappointment at not being consulted. The ASO wrote its submission:

> To date the basis on which the decision to reduce funding for cataract surgery to such a degree is unclear and has not been disclosed. There was no consultation with health care providers or consumers prior to the announcement of this decision. The result of this lack of consultation is that

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31 Mr David Learmonth, *Proof Committee Hansard*, 14 July 2009, p. 27.

32 Department of Health and Ageing, *Submission 4*, p. 25.

33 Dr Hilary Joyce, *Proof Committee Hansard*, 14 July 2009, p. 31.

34 Dr Andrew Pesce, *Proof Committee Hansard*, 14 July 2009, p. 41.

> a decision has been taken with a number of adverse consequences for the community. These consequences have wide ramification for the health of the aging population.[35]

3.46 In its submission, DoHA responded to the AMA's criticism that the Department had failed to adequately consult in the lead up to the bill being introduced into Parliament. It explained that the report—to be tabled in Parliament—was embargoed and could not be publicly released. Further:

> CHERE provided the AMA with a summary of the issues discussed at their meeting and the AMA agreed that this was an accurate representation of the discussion. This summary was included in the EMSN Review report as an attachment and posted on the Department's website on the day that the report was tabled in Parliament. The Department has checked with CHERE whether there was any mention at this meeting of the timeframe of July for completion of the report. CHERE has confirmed that a July report date was not advised. Their contract required the report to be complete by early April 2009.[36]

Committee view

3.47 Notwithstanding the Department's explanation, the committee is concerned that key stakeholders are dissatisfied with the recent consultation process. It is a legislative requirement that the Minister initiate an independent review of the EMSN, and it is only proper that the findings of this review should contribute to the executive's decision-making process in any amendments it makes to the safety net. In future, the process will work through legislative instruments that are based on parliamentary scrutiny and any variation to the cap will be reliant on effective consultation. The committee urges DoHA to ensure that the methodology and key findings of future reviews of the EMSN are thoroughly discussed with key stakeholders before legislation is brought before Parliament.

Recommendation

3.48 The committee recommends that the bill be passed.

Senator Claire Moore
Committee Chair

August 2009

35 Australian Society of Ophthalmologists, *Submission 6*, p. 5.

36 Department of Health and Ageing, *Submission 4*, p. 53.

ADDITIONAL COMMENTS BY COALITION SENATORS

Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

1.1 The Coalition introduced the Extended Medicare Safety Net (EMSN) in 2004 to assist with the out-of-pocket expenses of all Australians. The legislation allowed the Minister to initiate an independent review of the 'operation, effectiveness and implications' of the Act. The former Health Minister engaged the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney in 2007 to complete a review. This Bill is largely a result of the review's findings.

1.2 The Coalition welcomes the review and Government consideration of how to address some of its concerns. However, Coalition Senators believe that a number of submissions raised legitimate concerns with the direction taken by the Government to address the review and the consequences on certain Australians accessing medical services. These concerns relate to a lack of industry consultation by the Department in designing this Bill, and the discrimination against patients receiving the medical services targeted by this Bill. Better consultation would have allowed the Government to investigate the consequences of the measures.

Lack of Industry Consultation

2.1 The Australian Society of Ophthalmologists noted in its submission that the Government made "no consultation with health care providers or consumers prior to the announcement of this (Bill)…the result is that a decision has been taken with a number of adverse consequences for the community."[1] The Australian Medical Association submitted that it would be better practice "…for the Government to consult the medical profession when it is developing policy on Medicare rebates so that there can be proper scrutiny of the practical effect of the measures in the Bill and the draft Ministerial determination."[2]

2.2 The Chair's report contends that the Committee is satisfied that the "Department has adequately responded to the concerns put to the committee by various stakeholders." Coalition Senators do not believe that the concerns of industry groups have been adequately considered by the Government. Despite the claims by the Department of constant consultation, it appears that the potential consequences to certain patients has not been adequately considered. Better consultation with the profession would have allowed a fairer assessment of the impact upon these patients.

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[1] Australian Society of Ophthalmologists (ASO), *Submission 6*, p.4.

[2] Australian Medical Association, *Submission 1*, p.2.

2.3 Proper consultation with the industry leading to a Ministerial Determination on the level of a particular cap will be essential to the operation of this Bill. Coalition Senators recognise the undertaking by the Department to continue working with the profession "leading up to the implementation of this measure."[3]

Discrimination of Certain Medical Services

3.1 The Bill will allow a restriction on the rebate for costs incurred for outside-of-hospital Medicare services on certain items. These items include: all obstetric services including some pregnancy related ultrasounds; all Assisted Reproductive Technology services (IVF treatments); a type of cataract surgery; and, a type of varicose vein surgery. Coalition Senators recognise the need to monitor costs relating to the operation of the EMSN and understand that some providers have increased costs to absorb the Medicare rebate provided. However, Coalition Senators wish to raise concerns of submissions made contending that the Bill will increase the costs of medical services provided to certain groups of Australians and the effect is discriminatory in nature.

3.2 The Australian Medical Association (AMA) submits that "it is inevitable that patients will incur greater out-of-pocket costs for these services as a consequence of this measure". The increases are despite the Government promising before the 2007 Federal Election that "with about one million people each year receiving some cost relief from the safety net, Federal Labor will not put more pressure on family budgets by taking that assistance away."[4] The disturbing pattern of the Government breaking its election promises is a concern.

3.2 Coalition Senators are particularly concerned at the potential cost increases for families and rural Australians. The AMA's analysis of the draft Ministerial Determination is that costs for normal obstetric deliveries will increase "by around $466 for patients who are charged fees in the bottom quartile, and around $1,706 for patients who are charged fees in the top quartile."[5] The Australian Society of Ophthalmologists submit that "the economic viability of the delivery of eye care to rural and remote communities will be destroyed".[6] This will lead to more patients moving to the public hospital system, more congestion and increased costs to both insured and uninsured patients.

3.3 The Chair's report contends that, whilst capping these items will have "the desired effect of curtailing public expenditure on the extended safety net", the actual causes for cost increases have not been determined. The report recognises:

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[3] Department of Health and Ageing, *Submission 4*, p.25.

[4] Rudd, Kevin and Nicola Roxon. *Media Release* 22/9/07.

[5] Australian Medical Association, *Submission 1*, p.1.

[6] Australian Society of Ophthalmologists (ASO), *Submission 6*, p.2.

"…the difficulty of establishing a causal link between an increase in average fees for medical services and the range of factors that may have contributed to higher costs. Indeed it is highly likely that the recent increase in average fees for the services that the government proposes to cap is the result of several factors."

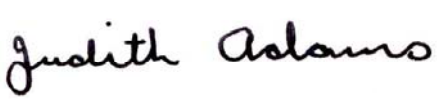
3.4 Coalition Senators are concerned that the Government does not have a clear idea as to why the costs of obstetric, IVF and cataract services have increased and that it proposes to increase out-of-pocket costs in order to save public finances. For example, Access Australia submits that the factors relating to rising costs for Assisted Reproductive Technology must be determined by consulting with the particular doctors accused of overcharging.[7] It is unfair to require certain Australians, such as families and those living in rural areas, to pay higher costs, without addressing the range of factors contributing to the higher costs of these services.

Conclusion

4.1 Coalition Senators believe that better consultation with the profession would have resulted in a better understanding of the factors placing upward pressure on the cost of certain medical services. The operation of the EMSN will require continued reviewing in order to ensure that the out-of-pocket costs to those Australians receiving these services does not increase unfairly and that these services continue to be available.

Sue Boyce
Senator for Queensland

Mathias Cormann
Senator for Western Australia



Judith Adams
Senator for Western Australia

John Williams
Senator for New South Wales

[7] AccessAustralia, *Submission 8*, p.1.

Additional Comments
Senator Rachel Siewert, the Australian Greens

Introduction

The Extended Medicare Safety Net (EMSN) was introduced in 2004 as part of the previous government's *Medicare Plus* reforms to provide individuals and families with an additional rebate for out of hospital Medicare services once an annual threshold of out of pocket costs was reached. The Act provides that once an individual or a member of a registered family reaches the out of pocket EMSN threshold, they are entitled to a Medicare benefit equal to 80 per cent of their out of pocket costs for that claim for the rest of the calendar year. There is currently no limit on the amount of benefit payable under the EMSN. The Explanatory Memorandum (EM) notes that this has led some doctors to increase their fees with the knowledge that the majority of the cost will be funded by the Government once the person has reached the EMSN threshold. This also has implications for those people that have not qualified for the EMSN benefits. The amendments to the *Health Insurance Act* proposed by the bill would create a mechanism enabling the Minister to determine a cap on the EMSN benefit payable.

The Australian Greens acknowledge this is a step in the right direction. There is evidence from the Centre for Health Economics Research and Evaluation (CHERE) [1]of significant and excessive fees being charged by certain medical practitioners. The Australian Greens support the move to instigate changes to the legislative framework and are broadly supportive of the provisions in this Bill.

However, while the Committee report does address the key issues raised in the course of the Inquiry, the Australian Greens wish to make some additional comments on a few of these issues and also make additional recommendations.

Key Issues

<u>Excessive Fees</u>

The Australian Greens believe the EMSN is an inflationary policy. The EMSN was designed to provide financial relief for those who incur high out-of-pocket costs and thereby make health care services more affordable. The EMSN appears to have little benefit for those in more remote areas or in lower socioeconomic groups. According to the CHERE report, 'the EMSN appears to be a relatively ineffective way to direct higher benefits to those households.' The report says that most of the EMSN benefits have flowed to services more often used by wealthier sections of the community, increasing the affordability of high-cost services but making little impact on the affordability of medical services for other sections of the population. The CHERE report describes the EMSN as 'poorly targeted policy because it

[1] 'Extended Medicare Safety Net Review Report 2009', by the Centre for Health Economics Research and Evaluation prepared for the Australian Government Department of Health & Ageing (UTS, 2009)

has not addressed one of the main barriers to access that many patients on low incomes face.'

The impact of the EMSN on fees is most pronounced for Medicare items that are usually associated with high out-of-pocket costs per service. The Australian Greens believe that providers know if they bill these items their patients are likely to qualify for EMSN benefits. Under these circumstances providers feel fewer competitive constraints on their fees.

Between 2003 and 2008 the fees charged by obstetricians for in-hospital services reduced by 6%, whilst the fees charged for out-of-hospital services increased by 267%. Similarly the fees charged by ART services fell by 9% for in-hospital services while the fees charged for out-of-hospital services increased by 62%.

The Australian Greens believe this shows that some doctors are structuring their billing to take advantage of the EMSN.

EMSN benefits are highly concentrated in certain types of services. In 2007 over 30% of all EMSN benefits helped fund obstetric services and 22% went towards assisted reproductive services. The EMSN has more than doubled the amount of Commonwealth funding going towards these two professional groups. Only 8% went towards funding general practice consultations.

The Australian Greens recognise the need to address the lack of constrains on excess fee increases. The Government estimates there will be net savings of $451.6 million over four years as a result of these measures. However this is a blunt instrument approach to the matter of excessive fees. The Built into this Bill is the assumption that the provider will be pressured into reducing their pricing by the patient rather than tackling the problem more directly. The Greens are concerned that this will cause considerable heartache for certain sections of the public, particularly in ART and obstetric services.

Cataract Surgery

The Australian Society of Ophthalmologists (ASO) noted that the Medicare reimbursement for cataract surgery as of November 2009 would be reduced from $623.70 to $307.20. It identified the 'most concerning effect' of this reduction as the 'economic viability of the delivery of eye care to rural and remote centres'. They were unequivocal: if the Medicare rebate is cut by 50 per cent, the cost of cataract surgery will be 'beyond the reach' of the 'average Australian'.[2]

The Australian Greens accept that improvements in technology have meant that cataract services can be provided more quickly and safely – up to one third of the time since the fee level was first set – but are particularly concerned about the implication these changes will have to provision of services in rural and regional patients. According to the Royal Australian and New Zealand College of Ophthalmologists (RANZCO), 'The economic viability of the delivery of eye care to rural and remote centres will very likely be destroyed.'[3]

[2] Australian Society of Ophthalmologists, *Submission 6*, p. 3.

[3] Royal Australian and New Zealand College of Ophthalmologists (RANZCO) response to Budget proposal, 2009

Recommendation 1: The Australian Greens recommend that the Bill be amended to include the provision of a Medicare provider number for cataract surgeon in rural and remote areas to ensure that the changes will not negatively impact on people in those areas.

Recommendation 2: The Australian Greens recommend that Bill is amended to include a provision for an independent evaluation of the impact of the caps measures with the report to be tabled in Parliament no later than 1 July 2011.

Senator Rachel Siewert
Australian Greens

Minority Report by Senator Nick Xenophon

1.1 These comments are confined to the likely effects of the proposed cap on the public subsidy for out-of-hospital Medicare services under the Extended Medicare Safety Net (EMSN).

1.2 As outlined in the majority report, the *Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* restricts the rebate for costs incurred for out-of-hospital Medicare services by introducing a cap on a variety of items described in the Budget Papers as incurring 'excessive' fees.[1] These items include, amongst other things, all obstetric services including some pregnancy related ultrasounds, all Assisted Reproductive Technology services and one type of cataract surgery. These measures which are due to take effect from 1 January 2010 are expected to provide savings of $257.9 million over four years.[2] However, there is concern that in seeking to achieve these savings the Government may unleash unintended consequences, which will be counterproductive, lead to adverse health outcomes and subsume the projected savings.

1.3 Evidence from AccessAustralia over the proposed changes and the impact on IVF services states that 'if this Bill is passed, it will deny many hardworking Australian families their last chance to have a child.'[3]

1.4 AccessAustralia's submission and evidence that the changes will adversely affect the one in six who need medical help with infertility[4] indicates the potential extent of the impact of these changes (with many couples not realising they may have a fertility problem until they decide to have children).

1.5 A key underlying premise of the Government's rationale for these changes is:

> There is evidence that the Extended Medicare Safety Net has enabled some doctors to charge excessive fees resulting in windfalls being paid by taxpayers through Medicare. The cap will encourage patients whose doctors charge excessive fees to seek other providers who charge more reasonable fees.[5]

However, evidence from Dr Richard Henshaw indicates when the costs for a cycle are increased there is increased pressure for multiple embryos to be used, which increases the chance of medical complications, multiple births and neonatal intensive care.[6]

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[1] Budget 2009–2010, *Budget Paper No. 2*, http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2_expense-16.htm

[2] *Ibid.*

[3] AccessAustralia, *Submission 8*, p1.

[4] *Proof Committee Hansard*, 9 July 2009, p 44. See also evidence of Professor Peter Illingworth, President, Fertility Society of Australia, *Proof Committee Hansard*, 9 July 2009, p 37.

[5] Budget 2009–2010, *Budget Paper No. 2*, http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2_expense-16.htm

[6] Dr Richard Henshaw, Chairman, IVF Directors Group of Australia and New Zealand, *Proof Committee Hansard*, 14 July 2009, p 35.

AccessAustralia points out that:

> More than 40,000 individuals were able to access IVF services with the support of the Medicare Safety Net in 2008 and nearly 11,000 babies are born each year as a result. Based on estimates reported in The Australian newspaper (2/4/09), the $42 million spent on IVF in the Safety Net equates to approximately $4,500 for each of these IVF children born last year. IVF therefore is a cost-effective, valuable investment given the significant return each of these children, as productive Australians, will bring their families and this country of ours.[7]

1.6 Similar concerns about the unintended consequences the proposed changes could have on ophthalmology services have also been expressed, in terms of increased out-of-pocket expenses for patients, greater congestion in the public hospital system and reduced access for rural and remote settings (including indigenous communities), among others.[8] 'A greater risk of falls (x2), hip fractures (x8) in elderly Australians as a consequence of poor vision'[9] has been cited as another factor.

1.7 Dr Hillary Joyce set out the concerns of obstetricians and gynaecologists on behalf of the National Association of Specialist Obstetricians and Gynaecologists. Dr Joyce highlighted that 'the Medicare Safety Net has provided hundreds of thousands of Australians with the security of affordable service access when they need it, particularly those faced with high-cost services or recurrent medical expense.'[10]

1.8 In addition to the issues raised with respect to IVF treatment, Dr Joyce pointed out that:

> Thirty per cent of women have their children under care of private obstetricians, and if there is less choice to do so because of reduced affordability then there will also be an impact on the public system, which is already overloaded, if those women turn to the public system to help them out of their predicament. Certainly, for the future mothers we do see reduced choice, reduced access, and reduced affordability.[11]

1.9 The rationale for these changes, namely excessive fees and overcharging, could be tackled by alternative means including:

- giving patients the right to informed financial consent with significant sanctions for medical practitioners who do not comply;

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[7] AccessAustralia, *Submission 8*, p 1.
[8] Australian Society of Ophthamologists, *Submission 6*, p 3-4.
[9] *Ibid.*
[10] *Proof Committee Hansard*, 14 July 2009, p 30.
[11] *Proof Committee Hansard*, 14 July 2009, p 38.

- targeting practitioners for overcharging.

1.9 There appears to have been a lack of analysis and modelling by the Government over the potential unintended consequences (and additional costs) of the proposed changes, particularly in relation to IVF.

Recommendations

Recommendation 1

That the Bill not be passed in its current form until adequate assessment of the costs and implications of the proposed measures has been undertaken.

Recommendation 2

That the Government ought to pursue alternative approaches to deal with concerns of excessive charging including informed financial consent for patients.

NICK XENOPHON
Independent Senator for South Australia

APPENDIX 1

Submissions received by the Committee

1 Australian Medical Association
Supplementary information
- Opening statement tabled at hearing 14.7.09

2 Clacherty, Ms Peta

3 SANE Australia

4 Department of Health and Ageing

5 EMSN Review Project Team

6 Australian Society of Ophthalmologists (ASO)

7 Australian Nursing Federation

8 AccessAustralia

Additional information

Dr Peter Illingworth

Response to questions on notice arising from the hearing 9.7.09, received 29.7.09

APPENDIX 2

Public Hearings

Wednesday, 8 July 2009
Parliament House, Canberra

Community Affairs Legislation Committee Members in attendance

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Sue Boyce
Senator Mathias Cormann
Senator Mark Furner

Witnesses

Australian Health Insurance Association

Dr Michael Armitage, Chief Executive Officer

Australian Private Hospitals Association

Dr Michael Roth, Executive Director

Dr Barbara Carney, Director, Policy and Research

Mr Ian McAuley, Fellow, Centre for Research in Public Sector Management

Dr John Deeble, Private Capacity

Wednesday, 9 July 2009
St James Court Conference Centre, Melbourne

Community Affairs Legislation Committee Members in attendance

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Sue Boyce
Senator Mark Furner

Witnesses

Australian Unity Health Limited

Amanda Hagan - Group Executive, Healthcare

BUPA Australia

Mr Mark Engel, Director Marketing, Product and Corporate Affairs

Ms Brooke Lord, Head of Industry Relations

Health Insurance Restricted Membership of Australia (HIRMAA)
Mr John Rashleigh, President
Mr Ron Wilson, Executive Director

Private Health Insurance Intermediaries Association
Mr Peter Kerestes, Chief Executive Officer

Friday, 10 July 2009
Parliament House, Canberra

Community Affairs Legislation Committee Members in attendance
Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Mathias Cormann
Senator Mark Furner

Witnesses

HBF
Mr Rob Bransby, Managing Director
Mr Andrew Walton, Manager, Public Affairs

Health Consumers Council of Western Australia
Mr Timothy Benson, Chairman
Ms Michele Kosky, Executive Director

Australian Medical Association, Western Australian Branch
Mr Peter Jennings, Deputy Executive Director

St John of God Health Care
Dr Shane Kelly, Deputy Executive Director

Tuesday, 14 July 2009
Parliament House, Canberra

Community Affairs Legislation Committee Members in attendance
Senator Claire Moore (Chair)
Senator Sue Boyce
Senator Carol Brown
Senator Mathias Cormann
Senator Mark Furner
Senate John Williams
Senator Nick Xenophon

Witnesses

Department of Health and Ageing

Mr David Learmonth, Deputy Secretary, Departmental Executive

Mr Tony Kingdon, First Assistant Secretary, Medical Benefits Division

Ms Samantha Robertson, Assistant Secretary, Medical Benefits Division, Medicare Benefits Branch

IVF Directors Group

Dr Richard Henshaw, Chairman IVF Directors Group

Dr David Molloy, Deputy Chairman IVF Directors Group and Vice President NASOG

Dr Hilary Joyce, President National Association of Specialist Obstetricians and Gynaecologists (NASOG)

Dr Andrew Pesce, President, Australian Medical Association