RACGP response to the Medicare Safety Net Reform Consultation

November 2024

RACGP

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1. About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. The RACGP trains more than 90% of Australia's GPs. For more than 60 years, we've supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

2. Summary of RACGP recommendations

The RACGP **does not support**:

- annual indexation to the Medicare Safety Net without measures to address the cost of care
    - given the previous 10 year freeze to the Medicare patient rebates as any indexation moves the Safety Nets further away from appropriate amounts, penalising patients
- the fixed 12 month period for Safety Net qualification as an inflexible adherence to the calendar year, as it excludes many patients from qualifying, whereas a rolling 12 month period would be a fairer approach.

The RACGP **supports**:

- lower of the MSN threshold for both individuals and families, potentially based on income
- visits to general practice continuing to contribute to the Medicare Safety Net
- increasing the transparency and consistency of the Medicare Safety Net
- continued evaluation and adjustment of the Safety Net as this is crucial to meeting the evolving health needs of all Australians
- introducing reforms to the Medicare Safety Nets to ensure they serve an important role in protecting health care consumers from the impact of high out-of-pocket costs

The RACGP **requests:**

- an opportunity to be a member of the Medicare Safety Net Reform Working Group (MSNWG), tasked with reviewing current arrangements to ensure appropriate representation of GPs.

3. Summary of RACGP position

To reduce inequalities there must be changes to the MSN to increase transparency and protect the most at risk patients. The MSN thresholds are too high to deliver meaningful benefits to more than a small handful of Australian's each year. In a recent poll, **66% of respondents agreed that the current 2024 Medicare Safety Net thresholds were set too high.** The RACGP is asking the federal Department of Health and Aged Care (DoHAC) to develop an immediate solution to patients' rising out-of-pocket costs and address the shortfall of the current Medicare Safety Net (MSN).

Fundamentally, fixing the Medicare Safety Net will not address the root cause of higher out-of-pocket costs for patients. These increasing costs will only be effectively addressed when MBS patient rebates more accurately reflect the actual cost of delivering a quality health service. However, we do appreciate, fixing the MSN in the meantime could provide an essential buffer for some patients during a cost of living crisis.

Australia's political leaders must deliver health policy that will keep all Australians healthy and out of hospitals. **If Medicare is to be properly strengthened, it must be adjusted to deliver universal and equitable health care to all.** Additional investment in patient care within general practice needs to be at the heart of any reforms. The RACGP has long been calling for an increase in all Medicare rebates for Level C and Level D consultations by at least 20% to ensure patients can access the care they need. We are also calling for a loading to MMM 3–7 areas, as per the distribution of the bulk-billing incentive.

Specific recommendations

The RACGP specifically recommends the DoHAC:

- lower of the MSN threshold for both individuals and families, potentially based on income
- implement a freeze on MSN indexation while Medicare patient rebates are increased to an adequate amount ie. a period of funding titration
    - this needs a particular focus on the Extended Medicare Safety Net (EMSN) General stream which is well above the current rate of general inflation
- introduce a 'rolling' 12 month period for Safety Net qualification as people may be excluded from the Safety Net unfairly because their costs are split between calendar years
- investigate the viability of developing a federally funded National Secondary Consultations Scheme – where GPs get advice about patients directly from non-GP specialists – reducing the number of non-GP specialist referrals, lowering the out of pocket costs for patients and ensuing appropriate waiting times
- enhance technology use to streamline claims and offer real-time tracking of expenses to ensure patients understand how close they are to reaching the MSN threshold
    - a notification during the Online Patient Verification (OPV) process would provide better transparency for healthcare professionals
- investigate implementing a differential in the MSN – a separate stream for GPs versus non-GP specialists. This would help to reduce high healthcare and integrate preventive healthcare measures within MSN programs as a future approach. Encouraging primary care and preventive visits that help manage chronic conditions could ultimately lower out-of-pocket costs for patients who otherwise may delay essential care.

4. Response to the Department's Review of Medicare Safety Net reform

4.1 Do you believe Medicare Safety Net arrangements have been effective in assisting health care consumers that incur high out-of-pocket costs for services provided out-of-hospital? Why or why not?

Medicare Safety Net arrangements, particularly the Extended Medicare Safety Net (EMSN), are generally effective in helping patients who incur high out-of-pocket costs for out-of-hospital services, especially those requiring frequent visits to non-GP specialists, allied health, or advanced diagnostics. By capping out-of-pocket costs for eligible individuals and families once they reach a threshold, it provides significant financial relief, particularly for people with chronic health conditions or high healthcare needs.

However, its effectiveness is inequitable across different groups. While wealthier patients who see high-cost non-GP specialists might receive substantial benefits, patients in lower socio-economic groups, or those without access to non-GP specialists, may not benefit as much. This inequity reduces the MSNs overall effectiveness in addressing healthcare costs for the entire population.

While the MSN arrangements have proven somewhat effective in reducing out-of-pocket costs for certain patients, ongoing efforts are needed to enhance accessibility, simplify the process, and ensure that all Australians can fully benefit. For example, one of the strengths of the MSN is its ability to provide a buffer for eligible patients, particularly vulnerable cohorts such as healthcare card holders or older adults, who typically have high medical expenses, particularly for chronic conditions. However, the effectiveness of the MSN is not without its challenges. Many patients are reporting that health services are becoming increasingly unaffordable. For example, the proportion of people who reported that cost was a reason for delaying or not seeing their GP when needed increased in 2022-23 compared to 2021-22 (7.0% to 3.5% respectively).[1]

In addition, the complexity of the program leads to confusion, leaving many patients unaware of their eligibility or the full extent of the benefits available to them. Therefore, while assisting some, they have not been universally effective in their aim to reduce financial barriers for individuals who require frequent medical care or supporting better access to essential health services such as GPs.

The MSN aims its resources towards those who can afford out of pocket costs. If patients delay going to see their GP because they simply cannot afford it, there is no Medicare rebate or Safety Net – and this is becoming an increasing problem impacting access to healthcare across income brackets across the whole of society.

To some degree, the MSN works against health equity. Prior to the cost of living crisis, it was a helpful policy for those with middle income, who may have been able to pay out of pocket fees at the time of consultation, but then struggle financially afterwards and with the accumulation of fees. With consideration to this, if the MSN is not remodelled significantly, with a health equity lens, other health policies need to be introduced to offset the inequities brought about by this one.

GP Case study #1: Cost of living crisis and its impact on health

Dr Rebekah Hoffman, a Sydney GP, said she is seeing firsthand patients presenting later and sicker due to the cost of healthcare:

'Whereas they maybe previously came at the beginning of an illness, it might be day two, four, five into the illness when they're presenting now. The things that we really want to make sure doesn't slip off is all of the great stuff that GPs do around preventive care, and so it's really important that patients can afford to see a GP and to see a GP regularly.

'That saves lives and that's what patients need, but it's also really important to pick these things up from a financial point of view, because if we can identify these things early, then that's a cost saving for the Government as well.'

4.2 Are there any aspects of the Medicare Safety Net arrangements that could be changed to achieve more equitable outcomes?

Financial barriers to accessing healthcare

Rising out-of-pocket costs are continuing to place more pressure on affordable patient care. Patient financial issues were one of the top concerns GPs reported in our 2024 Health of the Nation survey. GPs effectively coordinate and plan care for patients. However, high out-of-pocket costs for medical non-GP specialists or healthcare services prevent patients accessing the care they require. **The continually increasing MSN only serves to exacerbate existing cost barriers and unequitable health outcomes rise as a result**.

Many patients are forgoing essential medical care due to out-of-pocket gap fees alongside cost of living pressures which continue to rise. Conversely, these patients cannot afford the care they need from their trusted GP. All governments need to act to ensure the cost of living does not increase inequality in Australia on access to health care. High out-of-pocket payments for community-based care, including general practice, can unnecessarily push people towards hospital care.[2]

While the Government's tripling of bulk billing incentives has helped more GPs bulk bill specific groups, including children, pensioners, and healthcare card holders, more needs to be done to ensure care is affordable for the rest of the population.

In addition, if the aim of the MSN policy is to address access to healthcare for middle income earners, then the program should be explicit about that. However, as a health policy, it makes health equity worse and directs public funding to people who can afford out of pocket fees and shifts away from general practice towards secondary care. Directing health system funding towards general practice will create better health outcomes for patients overall. A fundamental problem is that patients cannot receive any benefit from the MSN if they cannot afford initial out of pocket costs. Many areas have local programs for Aboriginal and Torres Strait Islander people that fund non-GP specialist gap fees. This is welcomed as it improves access to specialist care for Aboriginal and Torres Strait Islander communities who often cannot afford out of pocket fees.

Patients who are financially strained rarely consider the rebates they might get back in the future as the key barrier is being able to afford the initial co-payment in the first place. All the examples of co-payments in the consultation paper are

plausible, and yet not all patients could afford them. Even if they could become eligible, they would need to have to have disposable money available for the upfront payment before receiving a rebate back from the government.

Medicare Benefits Scheme (MBS) indexation vs Medicare Safety Net indexation

Estimates suggest the Medicare freeze resulted in a $3.8 billion loss to general practice since being introduced in 2013. The MSN coupled with this freeze has increased the cost of care for all patients. MSN thresholds are indexed annually in line with the Consumer Price Index (CPI) while patient rebates remained frozen for many years. **The value and intention of the MSN benefit has eroded over time as out-of-pocket costs increase and patient rebates are not increased at the same rate.**

From 1 July 2023, Medicare items were indexed by 3.6 per cent, whereas in January 2023 the MSN Net threshold increased by 7.3 per cent. This inadequate indexation and imbalance of application has effectively resulted in a cost shift from the government to healthcare providers and patients.[3]

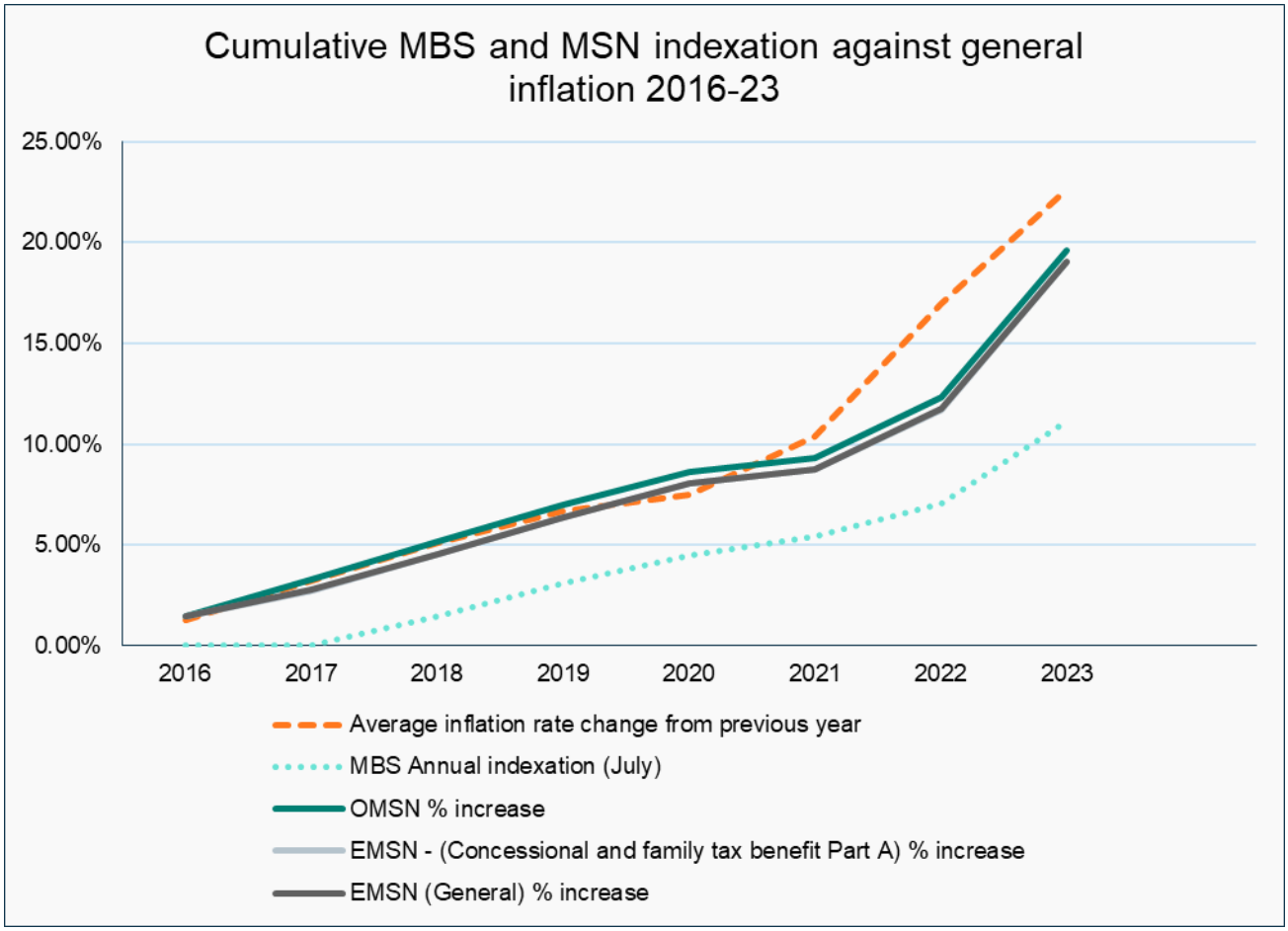

Figure 1. Cumulative MBS and MSN indexation vs general inflation from 2016-24

Data sources: Indexation measured via Consumer Price Index (CPI) reported by the Australian Bureau of Statistics (ABS), MBS annual indexation and MSN annual indexation data reported by the Australian Department of Health and Aged Care MBS Online.

4.3 Have there been unintended consequences as a result of the introduction of the EMSN? If so, how effective are current policy settings in reducing or limiting their impact and what other policy changes should be made?

Ineffectiveness of Medicare Safety Net thresholds

In the context of reduced bulk billing and rising out-of-pocket costs, the MSN thresholds are set too high to be effective in tackling the costs of accessing basic health care. Instead, they are focused on covering high cost non-GP specialist fees.[4]

The Extended Medicare Safety Net (EMSN) has not been reviewed in well over a decade and like the MBS, has not kept up with inflation.[5] The EMSN is set at a level that is excessive, with only a small number of people reaching the annual $2,414 EMSN threshold for out-of-pocket costs before they receive 80 per cent of gap fees back from the government.[5] The restrictive caps on the maximum accumulation amount and the MSN benefit have introduced an increasingly harmful effect on patient access to clinically necessary care. This is particularly egregious for patients during an extended cost of living crisis and impacts their ability to afford the healthcare they need.

In addition, Health Care and other Commonwealth concession cards are an inaccurate indicator of need, with many very low income earners not receiving benefits[4]. The EMSN also fails to address the support required for those with chronic disease who are likely to be from low socioeconomic populations. A lower threshold would be more likely to see these types of costs picked up by the safety net, with important benefits for access to GP level health care.[4] Lowering the EMSN would be beneficial to patients in low socio-economic areas, where higher burdens of disease of more likely.

Inflated costs to patients from non-GP specialists

One area for improvement is to reassess the EMSN's benefit distribution. Higher-income individuals, particularly in metro areas, often access high-cost non-GP specialists more frequently, which disproportionately benefits them. On the other hand, people in rural or remote areas, where access to non-GP specialists is limited, might see fewer benefits from the program. To create more equitable outcomes, adjustments could be made to ensure that financial relief better supports lower-income people or those with reduced access to high-cost non-GP specialists. For example, tiered threshold based on income.

The EMSN has also unintended consequences relating to the concerning misuse of inflation of consultation prices. For example, some non-GP specialists and providers, aware of the additional financial coverage offered by the MSN, may raise their fees, knowing patients will be reimbursed at a higher rate. This fee inflation undermines the intent of the safety net and drives up overall healthcare costs. There is still a level of discretion providers have when setting their fees, particularly across the private sector. There was also a known issue regarding some non-GP specialists, such as those providing IVF services and obstetrics, requesting large upfront payments from patients in order to reach the safety net threshold immediately.

4.4 To what extent are Medicare Safety Net arrangements simple to understand and access? What can be done to reduce complexity and improve system administration?

The complexity of this program is a more significant barrier to people using it than the actual financial value it aims to provide. Unless this is addressed, it will ultimately fail to improve treatment costs for patients.

For example, GPs typically only become aware of the MSN when they process a claim and notice that the patient rebate exceeds the scheduled fee. At that point, they usually inform the patient that they are nearing the safety net threshold, leading to a larger rebate. It's important to explore ways to better educate patients about their entitlements, including the MSN.

In addition, the administration required for patients to complete for registration (MS016 form), and which may be a barrier for those with varying levels of formal education, low health literacy and those who speak English as a second language.

An effective and efficient system to protect patients against large, and frequently unexpected, out-of-pocket expenses is critical.[4] This goal can be realised by revitalising a comprehensive health care system with adequate funding for services, with an aim to ensure accessibility and affordability.

4.5 Does more need to be done to improve awareness and understanding of Medicare Safety Net arrangements in the community? How can this be achieved?

There is a clear social gradient with lower health literacy associated with lower socio-demographic factors. Some of the people that most need to be engaging and interacting with healthcare providers are more likely to find it difficult. Patient populations at greater risk of poor health literacy, medication literacy, and sub-optimal use of medicines include older

people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds, and people with low literacy and/or low socioeconomic status. The MSN is difficult to understand for many health professionals too. This may be achieved by factsheet development, webinar series and simplifying the MSN overall. We also note that improving awareness and understanding of a complex system that works against health equity does not address the core issues or intention of the MSN.

4.6 Do you have any other suggestions for improving the operation of Medicare Safety Net arrangements that you have not covered elsewhere?

A safety net is very much like the ambulance at the bottom of the cliff rather than the fence at the top[4]. We need to place more value on general practices within our health system, and that means looking at the funding that goes into general practice. Governments need to shift funding from the end of the line in hospitals back to the start, ensuring this appropriately values the time that GPs spend with patients.

In addition, the MSNs need to be adjusted significantly to ensure they do not function against health equity or other health policies and programs need to be in place to counter this and improve health equity.

The RACGP recommendations are outlined on page 3.

5. Conclusion

Increased funding for primary care is an effective solution to address the rise in complex conditions and disparities in health outcomes for patients across Australia. Coordinated and continuous care delivered by a patient's GP who knows them and their history is essential. Any solution to the MSN funding model needs to provide genuine support for patients and ensure that equitable outcomes are at its heart. **Australia's political leaders must deliver a renewed Medicare Safety Net health policy that will keep all Australians healthy and out of hospitals, particularly those most in need.**

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6. References

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