Medicare Safety Net Reform

Australian Government, Department of Health and Aged Care

Asthma Australia Submission, November 2024

ABOUT ASTHMA AUSTRALIA

Asthma is a respiratory condition that affects nearly 2.8 million Australians, with children being the most impacted. Asthma is responsible for at least one Australian death every day, making it a serious health concern. More than 30,000 people are hospitalised each year due to asthma, yet at least 80% of these hospitalisations are considered potentially avoidable.

Despite the prevalence of asthma, it is often misunderstood, causing fear and anxiety for those living with the condition. Asthma Australia has been the leading charity for people with asthma and their communities for over 60 years.

The challenges of climate change, unhealthy air, and health inequity make it more important than ever for people with asthma to have a voice. We search for new and progressive approaches to challenge the status quo. Our work is grounded in evidence and centred on the experiences of people affected by asthma. We believe by listening to those living with asthma, designing solutions with them, and influencing change, people with asthma can live freely, unrestricted by their asthma.

INTRODUCTION

Asthma Australia welcomes the opportunity to provide feedback on the Consultation Paper on Medicare Safety Net Reform (the Consultation Paper).[1]

MEDICARE SAFETY NETS

There are three Medicare Safety Nets that are designed to protect consumers from high out-of-pocket healthcare costs. These are the Original Medicare Safety Net (OMSN), the Extended Medicare Safety Net (EMSN) and the Greatest Permissible Gap (GPG). Medicare Safety Net benefits are calculated and processed automatically, although families and couples need to register as a family to combine healthcare costs to meet the thresholds of the OMSN and the EMSN faster. When the thresholds of the OMSN and EMSN are met, consumers pay less for their Medicare healthcare costs for the remainder of the calendar year.

THE IMPACT OF ASTHMA

Asthma is a complex, long-term condition with high prevalence and burden of disease in Australia. One in nine people have asthma (nearly 2.8 million people nationwide) and it is the fourth most commonly reported chronic condition.[2] Asthma was the eighth leading contributor to the overall burden of disease in Australia in 2022,[3] and is the leading cause of burden of disease for children aged 5–14 years.[4] In 2022-23, there were 31,107 hospitalisations for asthma, 91% of which were considered potentially preventable.[5]

This high prevalence and burden of disease has a significant impact on individuals and communities in Australia. People with asthma experience poorer health outcomes and quality of life.[6] They may live for a long period of time with disability associated with asthma, and experience reduced participation in employment, education, care responsibilities, sports and social events. A 2015 report, the Hidden Cost of Asthma, found asthma cost the healthcare system $1.2 billion, lost productivity due to asthma cost $1.1 billion, and the burden of asthma disease amounted to a cost of $24.7 billion.[7]

THE COST OF ASTHMA CARE

Effective management of asthma requires regular access to a range of medicines, devices and healthcare services, which all attract significant out-of-pocket costs. **People with asthma often have to make choices about the care and treatment they receive based on cost**. This is compounded by the cost-of-living crisis, asthma running in some families[8] and the high prevalence of comorbidities amongst people with asthma (around 65% of people with asthma are estimated to have one or more other chronic conditions[9]). While many chronic conditions are more prevalent with age,[10] for many people with asthma the condition can be present from childhood. With no cure for asthma, this means many people with asthma must manage associated healthcare costs over the life course. As a result, people with asthma may ration medicines or avoid essential healthcare appointments to the detriment of their health.[11]

While the Federal Government has in recent years implemented welcome policies to make medicines more affordable, including specific asthma medicines, many consumers struggle to meet the out-of-pocket costs associated with accessing essential Medicare services. This is particularly challenging for people with chronic conditions. The costs of accessing one-off or infrequent

healthcare services can be unaffordable for some people,[1/12] while out-of-pocket costs of healthcare can quickly mount for people with asthma. This is particularly the case for people with severe asthma who seek precision diagnosis through further testing, who might try or use a range of costly treatments (e.g. pulmonary rehabilitation) and who typically must regularly attend a respiratory specialist to help maintain control of their asthma.

High healthcare costs are a barrier to people with asthma accessing asthma care concordant with Australian asthma guidelines.[13] For example:

- **Australian data shows that less than 20% of people with asthma are being dispensed preventer medicine at a rate consistent with therapeutic use**.[14] Regular inhaled preventer medication is the most important medication in asthma care. It reduces the risk of asthma exacerbations and the need for emergency care, and improves overall health and quality of life.[15] Preventer medicines can only be accessed by seeing a prescribing healthcare practitioner.
- **Reliance on short-acting reliever therapy (short-acting beta-agonists, or SABAs) that can be accessed over the counter is common among people with asthma**. While for most people with asthma, relievers are an important medicine to temporarily relieve asthma symptoms and help gain control of asthma, their overuse increases the risk of poor health outcomes.[16] Evidence shows that using just three or more SABA inhalers a year increases the risk of asthma flare-ups, and using six or more SABA inhalers increases the risk of death.[17]
- **There is an overreliance on oral corticosteroids (OCS) in asthma care**.[18] OCS provide fast-acting relief of asthma symptoms following an acute asthma exacerbation and some people with severe asthma require OCS daily to maintain asthma control. However, OCS have significant adverse effects.[19] Asthma Australia is currently leading work on OCS Stewardship.

MEDICARE SAFETY NET REFORM

Asthma Australia strongly welcomes this consultation and its consideration of ways to improve the Safety Nets for consumers. It presents a significant opportunity to make access to essential healthcare services more affordable for people with asthma and address inequitable asthma outcomes related to cost.

After engaging with consumers in the development of this submission, we know that the Safety Nets in their current form do help to reduce the burden of high out-of-pocket costs for some people with asthma. However, we also know they have the potential to do more. To this end, we set out in our submission recommendations for reform of the Safety Nets that aim to help people with asthma afford to access the primary and specialist care services they need to better manage their asthma.

[1] Australia had the highest rate of primary care consultations missed due to cost (14% of people aged 16 years and over) in the OECD in 2021.

OUR SUBMISSION

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?

To inform our submission, Asthma Australia consulted with a small number of consumers about their experiences of using Medicare Safety Nets.[2]

- **Effective for families and consumers with high healthcare needs**

The consumers with whom Asthma Australia consulted, who used Medicare Safety Nets, accessed healthcare services often either as a family, or because they had severe asthma or other chronic conditions. These consumers spoke positively about Medicare Safety Nets[3] stating that, as they reached the threshold, they helped them to afford the healthcare services they needed. Positive feedback about Medicare Safety Nets included the following comments:

> *[Medicare Safety Nets] have been instrumental in helping our family manage high health care costs.*
>
> *In my experience, Medicare safety net [sic] has been a godsend.*
>
> *We have reached our Medicare safety net most years quite quickly and it has really helped us financially.*
>
> *Very helpful. I have multiple chronic diseases including severe asthma so reach concession safety net by April.*

One consumer explained that as they meet the Safety Net threshold quite early in the year, it helped their family to afford to see their preferred specialists.

Notwithstanding these benefits, some consumers also suggested that lowering Medicare Safety Net thresholds would be beneficial as they currently meet them late on in the year, limiting their benefits.

> *Definitely helps make healthcare affordable, would be amazing if the threshold was lower though. Even as a family of 5 (4 with asthma and other health challenges) we don't hit the threshold for the safety net until fairly late in the year*
>
> *I usually reach the safety net around August but have had less specialist visits this year so not eligible. I think the $ to reach safety net needs to come down so specialist visits are more affordable.*

[2] Asthma Australia engaged with consumers drawn from members of our Consumer Advisory Council, our Asthma Champion network and members of the public with asthma.
[3] Consumers did not specify which Medicare Safety Nets they met.

- **Ineffective for some consumer groups, e.g. single people**

Some consumers told us that, despite accessing healthcare services regularly, they failed to reach Medicare Safety Nets as they were single. One consumer related not meeting the Safety Net to their reconsideration of their healthcare use due to cost.

> *[My experience is] negative, never reached it as single person despite seeing GP 2-3 times a week for a period and respiratory physician at least twice a year, even with private hospital admission.*
>
> *Never quite get there to use them, PBS safety net I use every year. My income is just too much for the low-income support, but I have started thinking twice about doctors' visits based on my pay week because of rising costs.*

Consumers who do not meet the thresholds of the OMSN ($560.40) and the EMSN ($811.80 for people who have a concession card/Family Tax Benefit Part A and $2,544.30 for others) do not benefit from their potential savings. For individuals and families on low incomes, the level of the thresholds may simply be too high to make healthcare affordable. These consumers may need to regularly choose between accessing essential healthcare services and spending their income on other needs.

As a result, Asthma Australia strongly recommends that the thresholds for the OMSN and EMSN are reduced so they can better support people on low incomes who have chronic conditions, comorbidities or multiple family members with chronic disease or high health needs, as well as single people. Lowering the thresholds so they better reflect and support people's available household income would help Medicare Safey Nets better achieve more equitable health outcomes by enabling people to access the healthcare they need. This recommendation was made by several consumers who we engaged with for this submission, including both people who currently reach the threshold and those who do not meet it.

> *Bring down the amount to be reached before you can access the safety net.*
>
> *[The Safety Net thresholds] need to be reviewed and lowered for chronic conditions.*

Recommendation 1: That the Australian Government lowers the thresholds of the EMSN and OMSN Safety Nets to better support the needs of:

- **People on low incomes who have chronic conditions, comorbidities, or multiple family members with chronic disease or high health needs, and**
- **People who are single.**

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?

Asthma Australia consulted with its Professional Advisory Board (PAC) members on this consultation. One PAC member suggested that the current Safety Nets might affect the consumer care delivered and result in the following potential unintended consequences:

- Healthcare providers and professionals might prioritise performing more medical interventions (e.g. another test) over, for example, deprescribing, social prescribing or educating consumers.
- Healthcare providers and professionals might perform more profitable schedule items that can help to meet the Safety Nets more quickly.

These suggestions reflect some of the unintended consequences reported by the Medicare Benefits Schedule Review Taskforce Final Report to the Minister for Health in relation to the EMSN.[20] Asthma Australia considers that it may be helpful to undertake research into how Medicare Safety Nets drive healthcare provider and professional behaviour and clinical decision-making pre and post Medicare Safety Nets being reached.

Recommendation 2: That the Australian Government considers undertaking further research into healthcare practitioner behaviour and clinical decision-making per/post the Safety Net thresholds being reached.

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?

Some consumers highlighted lack of awareness about Medicare Safety Nets, including their existence and the processes surrounding them.

> *Basically, I didn't know that there was a safety net.*
>
> *I think the Medicare safety net can be confusing and quite a few people I speak to didn't realise that there is a safety net.*
>
> *More awareness of how the Medicare safety net is calculated of each family or individual as to most it is a mystery.*

In fact, the level of lack of awareness amongst some consumers meant that several consumers assumed the consultation was about the Pharmaceutical Benefits Scheme (PBS) Safety Net. Consequently, some consumers suggested that more information about Medicare Safety Nets and how to access them is needed. This information should be consumer-friendly: easy to understand, with simple examples/case studies and graphics to facilitate consumer access.

Some consumers also noted that not everyone is aware that they must register as a family to access OMSN and EMSN Safety Nets. Asthma Australia would like to see this process widely promoted to ensure that all consumers are of aware of this benefit, as well as any processes to support future reform of Medicare Safety Nets in the ways recommended in Recommendation 1. Promoting the use of Medicare Safety Nets to consumer groups has the potential to support proactive health-seeking and thereby improve health outcomes.

Recommendation 3: That Australian governments support consumer understanding and awareness of Medicare Safety Nets with consumer resources that simply explain how consumers can reduce out-of-pocket healthcare costs, including the process to register as a family and other processes to support the reforms recommended in Recommendation 1.

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

Pulmonary rehabilitation (PR) is an effective therapy for people with long-term lung conditions including chronic obstructive pulmonary disease (COPD), bronchiectasis, pulmonary fibrosis and severe asthma. It consists of a six-to-eight-week group treatment program that includes both educational and exercise elements delivered by a team of healthcare professionals such as physiotherapists, nurses and occupational therapists. Through exercise, PR aims to improve people's exercise tolerance so they can live more independently and undertake daily activities. Through education, PR seeks to provide people with information about looking after their body and lungs, advice on managing their lung condition and using their medicines, and techniques to manage breathlessness.

Evidence shows that pulmonary rehabilitation improves people's ability to walk further and to feel less tired and breathless, with patients completing a program reporting higher activity and exercise levels, and an improved quality of life.[21] Pulmonary rehabilitation has been shown to support better self-management, fewer exacerbations, fewer admissions to emergency and fewer appointment in primary care.[22] However, although PR is currently available in hospital under the Medicare Benefits Schedule (MBS), it is not available via community healthcare providers. This not only deprives people in the community from equitable access to an effective therapy but also means that PR does not contribute to meeting the thresholds of Medicare Safety Nets. PR should be resourced with adequate MBS item numbers to ensure it can be provided to everyone who needs it, regardless of income and including people with severe asthma who access care in the community.

Recommendation 4: That the Australian Government undertakes a review of MBS items delivered in hospital that could also be delivered within the community, such as pulmonary rehabilitation, so they may contribute to the thresholds of Medicare Safety Nets.

REFERENCES

[1] Australian Department of Health and Aged Care (2024). Discussion Paper. Review of MBS Health Assessment items. July 2024. Available from: MBS Health Assessment Items Review Consultation Survey - Australian Government Department of Health and Aged Care - Citizen Space
[2] Australian Bureau of Statistics (ABS, 2018). National Health Survey: First Results 2017-18. ABS Cat no. 4364.0.55.001. Canberra.
[3] Australian Institute of Health and Welfare (AIHW, 2022). Australian Burden of Disease Study 2022. Canberra.
[4] AIHW (2023). Australian Burden of Disease Study 2023. Canberra.
[5] AIHW (2024). Principal diagnosis data cubes [Internet]. Separation statistics by principle diagnosis, Australia 2022-23. Canberra. [Internet]. Available from: https://www.aihw.gov.au/reports/hospitals/principal-diagnosis-data-cubes
[6] AIHW (2019). Asthma. Cat. no. ACM 33. Canberra: AIHW; Australian Centre for Asthma Monitoring (ACAM, 2004). Measuring the impact of asthma on quality of life in the Australian population. Cat. no. ACM 3. Canberra: ACAM, AIHW; ACAM, 2011. Asthma in Australia 2011. Canberra.
[7] Deloitte Access Economics (2015). The Hidden Cost of Asthma. Available from: https://www.nationalasthma.org.au/living-with-asthma/resources/health-professionals/reports-and-statistics/the-hidden-cost-of-asthma-2015
[8] Thomsen S.F. (2015). Genetics of asthma: an introduction for the clinician. Eur Clin Respir J. 2015 Jan 16;2.
[9] AIHW (2024). Chronic respiratory conditions: Asthma. Web article.
[10] AIHW (2024). Chronic conditions. Web article.
[11] E.g. Laba T.L., Jan S., Zwar N.A., Roughead E., Marks G.B., Flynn A.W., Goldman M.D., Heaney A., Lembke K.A., Reddel H.K. (2019). Cost-Related Underuse of Medicines for Asthma-Opportunities for Improving Adherence. J Allergy Clin Immunol Pract. 2019 Sep-Oct;7(7):2298-2306.e12.
[12] ABC News (2024) Cost of living continues to impact how often – if at all – Australians access health services. Available from: Cost of living continues to impact how often — if at all — Australians access health services - ABC News
[13] National Asthma Council Australia (NAC, 2022). Australian Asthma Handbook, Version 2.2. Melbourne: National Asthma Council Australia. Available online: https://www.asthmahandbook.org.au/
[14] Reddel H.K., Lembke K., Zwar N.J (2018). The cost of asthma medicines. Aust Prescriber, 2018;41:346.
[15] National Asthma Council Australia (2022). Australian Asthma Handbook, Version 2.2. Melbourne: National Asthma Council Australia. Available online: https://www.asthmahandbook.org.au/
[16] NAC, 2022.
[17] Loh Z.C., Hussain R., Balan S., Saini B., Muneswarao J., Ong S.C., Babar Z.U.(2023) Perceptions, attitudes, and behaviors of asthma patients towards the use of short-acting β2-agonists: A systematic review. PLoS One. 2023 Apr 20;18(4):e0283876.
[18] Cumulative dispensing of high oral corticosteroid doses for treating asthma in Australia - PMC (nih.gov)
[19] Blakey J., Chung L.P., McDonald V.M., Ruane L., Gornall J., Barton C., Bosnic-Anticevich S., Harrington J., Hew M., Holland A.E., Hopkins T., Jayaram L., Reddel H., Upham J.W., Gibson P.G., Bardin P. (2021) Oral corticosteroids stewardship for asthma in adults and adolescents: A position paper from the Thoracic Society of Australia and New Zealand. Respirology. 2021 Dec;26(12):1112-1130.
[20] Australian Department of Health and Aged Care, 2024.
[21] Blervaque, L., Préfaut, C., Forthin, H. et al (2021). Efficacy of a long-term pulmonary rehabilitation maintenance program for COPD patients in a real-life setting: a 5-year cohort study. *Respir Res* **22**, 79.
[22] Ozmen, I., Yildirim, E., Ozturk, M., et al (2018). Pulmonary Rehabilitation Reduces Emergency Admission and Hospitalization Rates of Patients with Chronic Respiratory Diseases. Turk Thorac J. 2018 Sep 13;19(4):170–175.