

# Out-of-pocket costs and affordability of Eating Disorder Medicare Benefits Schedule services using linked data



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## BACKGROUND

- Eating disorders (ED) are costly, both to individuals and society. Recent cost estimates were \$66.9 billion annually for Australia and \$60,654 per person annually<sup>1</sup>
- In Australia most (97%) individuals with eating disorders have reported financial hardship, whilst 20% of individuals with an eating disorder reported cost-related issues as the cause for cessation of treatment.<sup>2</sup>
- In 2019, Australia expanded eating disorder services to include 60 Medicare funded sessions (40 psychological sessions and 20 dietetic sessions) for eating disorder services,<sup>3</sup> however, evaluation of the affordability and out-of-pocket (OOP) costs for the newly introduced services has not been completed.

## METHOD

- Study was a cross-sectional survey design. The survey was sent to all Australians aged 15 years and older who had received a Medicare funded eating disorder service since 2019.
- The online survey comprised 48 questions, including demographics, Eating disorder Medicare Benefits Schedule (ED MBS) treatment type, the outcomes of care, treatment affordability and OOP costs. Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) data were linked to the survey answers by Services Australia if consent was provided.
- Descriptive statistics (frequencies, percentages and means) were used to characterise the sample, determine treatment affordability and identify who paid for the majority of costs.
- Mean, median and total OOP costs were identified for the sample using the linked MBS item, patient contribution and PBS item data and reported for both psychological and dietetic treatments.

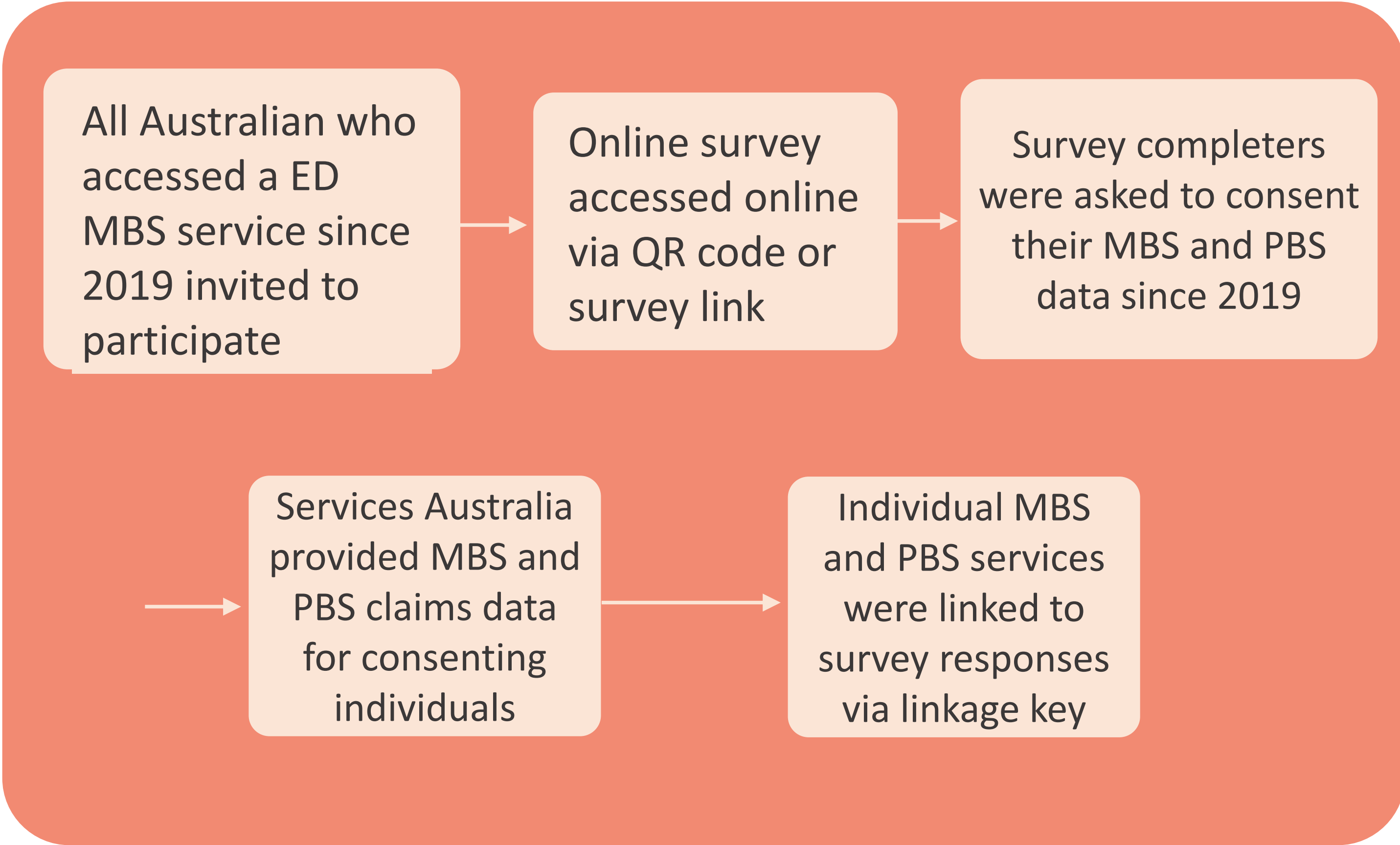
## RESULTS

- 2,421 individuals 15 years or older completed the survey (8.8% response rate) and of these we had linked MBS and PBS data available for 1,859 participants (77%).
- Most (65%) of the sample was less than 30 years old and the majority were female (92%) and born in Australia (89%).
- OOP costs associated with psychological treatment were: mean \$60 (SE 0.24), median \$33 (IQR \$20-\$100) and OOP costs associated with dietetic treatment were: mean \$51 (SE 0.36), median \$29 (IQR \$19-\$79).
- Almost half (47%) ceased psychological care and one third (33%) ceased dietetic sessions early due to the fee being too expensive.
- OOP fees were considered too expensive at \$934 for psychological services and \$480 for dietetic services.
- The most disadvantaged cohort were more likely than other cohorts to pay nothing for psychological (12% for most disadvantaged and 6% for least disadvantaged) and dietetic treatment (27% for most disadvantaged and 9% for least disadvantaged).

## OBJECTIVE

This study aimed to determine the out of pocket costs and affordability of the newly introduced Medicare funded Eating disorder services.

Figure 1. Survey sampling and MBS/PBS data linkage flow chart



**Psychologist**  
**OOP costs per session = \$60 (mean) and \$33 (median)**

**Dietetic OOP cost per session = \$51 (mean) and \$29 (median)**

Table 1. OOP cost by perceived affordability for participants with linked MBS claims data

	Median total co-payment (IQR)
I didn't pay anything for my psychological services, n=133	0 (0 - 217)
I paid a fee that was affordable for my psychological services, n=551	876 (304 – 1,828)
I paid a fee that was too expensive for my psychological services, n=1,013	934 (293 – 1,807)
Unsure of the fee I paid for my psychological services, n=132	760 (53 – 1,626)
I didn't pay anything for my dietetic services, n=177	0 (0, 0)
I paid a fee that was affordable for my dietetic services, n=531	335 (110 - 748)
I paid a fee that was too expensive for my dietetic services, n=577	480 (160 – 1,023)
Unsure of the fee I paid for my dietetic services, n=123	201 (0 - 647)

## CONCLUSION

- The fee associated with Medicare psychological and dietetic treatments was a factor in early cessation of treatment for many with eating disorders.
- Regular review and containment of consumer costs, via subsidies, are required to continue to provide affordable and equitable care.
- Reassuringly, individuals in the most disadvantaged group were more likely to have fully subsidized services.