

MEDICARE BENEFITS SCHEDULE REVIEW TASKFORCE

**INTERIM REPORT
TO
THE MINISTER FOR HEALTH**

2016

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LETTER OF TRANSMITTAL FROM THE TASKFORCE CHAIR

The Hon Sussan Ley MP
Minister for Health
Minister for Aged Care
Minister for Sport
Parliament House
Canberra ACT 2600



Dear Minister

It is with great pleasure that, on behalf of the Medicare Benefits Schedule Review Taskforce, I present this Interim Report to you. After several months of discussion, research, planning and trialling, we have successfully reached what might best be described as ‘the end of the beginning’. We have mobilised large numbers of clinicians, consumer groups and other stakeholders to design and begin a highly collaborative review of the MBS. While we have already seen signs of the challenges that lie ahead, we are united and have strengthened our conviction in the importance of delivering a high-quality set of recommendations from this Review.

As you have stated, this is a Review that is well overdue, with important outcomes at stake. Australia has reached an important juncture in the way we provide and fund health services. A modernised MBS, aligned with best practice and better able to accommodate changing models of care, is essential if we are to have an equitable, accessible and high-quality health system which will serve the needs of our community in the years ahead. This Review is led by clinicians with a firm commitment to genuine consultation with all relevant stakeholders—both providers and consumers of MBS services.

This Interim Report has been prepared in line with the Taskforce’s Terms of Reference. It articulates the need for change to the MBS with reference to the available research and evidence and the work that is already in progress both here and internationally. Australia is not alone in looking at the way health services are structured and funded to ensure that the public investment in health results in the provision of high-value care to patients, with fair and reasonable remuneration for providers. The experiences of colleagues in Canada, the United Kingdom and elsewhere have been evaluated and are relevant and useful to the Review.

This first Report also describes the Review methodology. At the core of this is significant stakeholder engagement with broad representation and input from clinicians, consumers, patient advocates, and other health disciplines including public health. I have been greatly heartened by the willingness of so many doctors and others to participate in the Review’s specialist Clinical Committees and Working Groups, and to share their expertise and experience believing that through this process we will end up with a better and fairer health system. In our early engagement, we have received excellent input on how we can gather meaningful consumer input to various parts of the Review and this has been incorporated in future plans.

The major Taskforce recommendations regarding changes to individual MBS items will be made in the latter part of 2016 and 2017. This Interim Report however describes

preliminary outcomes from the work of the early Clinical Committees, including items for which the consensus view was that these services do not have a place in contemporary practice and should not be MBS funded. Those items identified as potentially obsolete are currently being considered by relevant stakeholder groups.

Finally, this Interim Report offers observations from the Taskforce about the opportunities emerging, in part as a result of advances in technology and data management. This means that we are better placed than ever before to provide a high quality health system where resources are most effectively used to achieve the best outcomes for patients.

The ongoing support of clinicians, patients, advocates, members of the community and many others, is central to the Taskforce delivering recommendations to the Government which will align the MBS with best clinical practice and put in place a structure which will cater for the anticipated future changes in health practice as they occur. I am extremely grateful to my clinical and other colleagues who have already contributed to this endeavour, for their good will and their commitment to improving health outcomes in our communities in the decades ahead.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Bruce Robinson', with a stylized flourish at the end.

Bruce Robinson

GLOSSARY

Acronyms	Description
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
GP	General practitioner
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours ranging from failing to adhere to particular item descriptors or rules, through to deliberate fraud.
Low-value care	The use of an intervention which evidence suggests confers no or very little benefit on patients, or that the risk of harm exceeds the likely benefit, or, more broadly, that the added costs of the intervention do not provide proportional added benefits.
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, comprising an item number, service descriptor and supporting information, Schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure, test to which the relevant MBS item refers.
MSAC	Medical Services Advisory Committee
Multiple operation rule	<p>A rule governing the amount of Medicare benefit payable for multiple operations performed on a patient on the one occasion. In general, the fees for two or more operations are calculated by the following rule:</p> <ul style="list-style-type: none">–100% for the item with the greatest Schedule fee–plus 50% for the item with the next greatest Schedule fee–plus 25% for each other item.
Multiple services rules (diagnostic imaging)	A set of rules governing the amount of Medicare benefit payable for multiple diagnostic imaging services provided to a patient at the same attendance (same day). See MBS Explanatory Note DIJ for more information.
Obsolete services	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
Pathology episode coning	An arrangement governing the amount of Medicare benefit

Acronyms	Description
	payable for multiple pathology services performed in a single patient episode. When more than three pathology services are requested by a general practitioner in a patient episode, the benefits payable are equivalent to the sum of the benefits for the three items with the highest Schedule fees.
PBS	Pharmaceutical Benefits Scheme
PHCAG	Primary Health Care Advisory Group

EXECUTIVE SUMMARY

The Medicare Benefits Schedule Review Taskforce was established in June 2015 by the Minister for Health, the Hon Sussan Ley MP, following feedback from clinicians and the broader community that certain items on the MBS did not reflect clinical best practice and that the Schedule included anomalies that in some cases were creating distortions in services provided. There was also the broader issue that, some 30 years after its inception, the first thorough review of the MBS was well overdue. The MBS Review commenced in July 2015 with the first meeting of the Taskforce and an initial round of stakeholder consultations, and will continue through to mid-2017.

The rationale for this Review is very clear. The MBS is a key driver of the way health services are delivered into the community. Despite its importance to health outcomes and the sizeable public investment (\$20 billion in 2015–16¹, around 30 per cent of total Commonwealth health expenditure), the MBS has never been subject to a comprehensive review. Yet over this period there have been significant changes in best medical practice. This means there are specific MBS service items which were once appropriate but are now obsolete or of less value, overtaken by more effective treatments solidly backed by evidence. At the same time, many tests and procedures benefit patients but only when provided in the right clinical circumstances. Internationally, there is concern that many interventions provide little or no benefit to very many patients. This low-value care is displacing high-value care.

Furthermore, modern healthcare practice increasingly involves more multidisciplinary care delivered by teams of health professionals, and this service model does not sit neatly with the existing MBS structure.

In the early part of this Review, an extensive analysis of existing research and evidence, national and international was combined with widespread consultation. This involved doctors and other health professionals, public and private health service providers, regulators, data and systems experts, policy makers and commentators, and consumers and patient groups. There has already been a great deal of input from health professionals and from other stakeholders, and this has been invaluable in developing a plan for the next phase of the project. There has been significant engagement with clinicians who have brought their expertise and goodwill to the first reviews of specific MBS items.

Key outcomes to date

- The design of the process by which the Review will be undertaken.
- The Taskforce has held five stakeholder forums, with more than 100 organisations represented. In addition, more than 80 other meetings with stakeholders have been held.
- More than 1,500 surveys and more than 240 written submissions were received in response to the consultation paper released in September 2015. Approximately 300 health professionals provided specific examples of low-value and high-value usage through the online survey, as well as examples of potential obsolete items or misuse.

¹ Commonwealth of Australia, *Budget strategy and outlook, Budget paper no. 1, 2015–16*

- The establishment of the first five Clinical Committees - Gastroenterology, Ear Nose and Throat, Obstetrics, Diagnostic Imaging, and Thoracic Medicine. These first Committees have trialled the Review methodology.
- Approximately 100 individuals have agreed to participate in the first tranche of Clinical Committees.
- An initial 23 MBS items referred for stakeholder consultation.
- The establishment of a Principles and Rules Committee to review the regulations that underpin the MBS.
- Development of a timeline for establishing Clinical Committees in other disciplines through 2016.

The Review methodology, the processes adopted to support the Review and the guidance given to Committees will be monitored and refined based on the real-world experience of undertaking this complex and highly collaborative project.

The focus of this, the Taskforce's Interim Report, is on the following key areas:

- The need for review—outlining the critical reasons why the MBS is in need of evidence-based review.
- Methods—outlining the processes the Taskforce is adopting for conducting the Review, which have been tested through stakeholder consultation and early priority reviews.
- Preliminary results and considerations—reflecting on the outcomes of the Taskforce's initial activities, in stakeholder consultations and other early Review activities.
- Discussion and next steps—identifying a number of areas where there is a need for further consideration of issues raised in the Terms of Reference and the Taskforce's early activities.
- A provisional work programme for 2016—identifying the key priorities for the Taskforce in 2016.

The Taskforce anticipates making its first recommendations for changes to the MBS early in 2016, following stakeholder consultation on recommendations produced by the initial tranche of Clinical Committees.

TASKFORCE MEMBERSHIP AND TERMS OF REFERENCE

The Taskforce

The MBS Review process is being led by a group of clinicians appointed by the Minister. Chaired by Professor Bruce Robinson, Dean of the Sydney Medical School at the University of Sydney, the Taskforce's membership includes doctors working in both the public and private sectors with expertise in general practice, surgery, pathology, radiology, public health and medical administration. Consumers are specifically represented, and there is also academic expertise in health technology assessment. The Taskforce members are:

Prof Bruce Robinson	Chair, Dean of the Sydney Medical School
Dr Steve Hambleton	Deputy Chair, Representative of PHCAG
Dr Matthew Andrews	Clinical member (Diagnostic imaging)
Prof Michael Besser	Clinical member (Neurosurgery)
Dr Michael Coglin	Clinical member (Private provider)
A/Prof Adam Elshaug	Health technology assessment
Prof Paul Glasziou	Clinical member (General practice)
Prof Michael Grigg	Clinical member (Surgery)
Dr Lee Gruner	Clinical member (Medical administration)
Ms Rebecca James	Consumer representative
Dr Matt McConnell	Clinical member (Public health)
Dr Bev Rowbotham	Clinical member (Pathology)
Prof Nick Talley	Clinical member (Medicine)
Dr Megan Keaney	Department of Health, <i>ex officio</i>

Terms of Reference

1. An early, high-level review of the MBS as a whole to identify priority areas taking account of factors including concerns about safety, clinically unnecessary service provision and accepted clinical guidelines.
2. From this high-level review, identify Review topics and assign priority to nominated topics, providing this initial advice to the Minister for Health by late 2015.
3. Commission evidence-based reviews that rely on assessment of literature and data by Working Groups.
4. Analyse the advice from the Working Groups and, in turn provide advice to the Minister, including advice on the evidence for services, appropriateness, best practice options, levels and frequency of support through Medicare.
5. Monitor the outcome of MBS reviews and trends in MBS growth to inform an ongoing cycle of reviews, including advising on a system of ongoing analysis of MBS data, integration of other relevant available data, policy development and implementation.

6. Advise on a departmental programme of work that aims to update the *Health Insurance Act 1973* and regulations (MBS 'rules') that underpin MBS funding.
7. Provide advice to the Minister about the MBS and related health financing issues, as appropriate.
8. Engage with health consumers, medical professionals, peak bodies and other stakeholders to seek their views about appropriate Review approaches and processes.

The Taskforce's remit intersects to varying degrees with that of the Primary Health Care Advisory Group (PHCAG) in relation to primary care MBS items, and the Medical Services Advisory Committee (MSAC) in relation to the adoption of new MBS services. The Taskforce will take care to ensure that PHCAG and MSAC are apprised of its activities and that benefits from coordination are realised where possible.

INTRODUCTION

What the Taskforce is seeking to achieve

At its first meeting, the Taskforce articulated its vision for the Review, as follows:

To ensure that the Medicare Benefits Schedule provides affordable universal access to best practice health services that represent value for both the individual patient and the health system.

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

1. Affordable and universal access—The evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic with some rural patients being particularly under-serviced.
2. Best practice health services—One of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base where possible. Although MSAC plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
3. Value for the individual patient—Another core objective of the Review is to have a MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
4. Value for the health system—Achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

Broadly, the Taskforce's focus is on reviewing the existing MBS items, with an initial emphasis on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief there is considerable scope to review and advise on all aspects which would contribute to a modern, transparent and responsive system. This includes not only making recommendations about new items or services being added to the MBS, but also about a MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach and seize this unique opportunity to recommend changes to modernise the MBS on all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues.

Another key project for the Taskforce will be the development of a mechanism for the ongoing review of the MBS once the current Review is concluded.

The current Review follows and complements several previous programmes aimed at updating and strengthening the evidence base of the MBS. These include the 2009 Review

of Health Technology Assessment, the 2009–10 MBS Quality Framework and the Comprehensive Management Framework for the MBS, announced in the 2011–12 Budget.

These activities supported the evidence-based approach to MBS funding instituted by the establishment of the MSAC in 1998. MSAC's role is to provide advice to the Government about the evidence for safety, clinical effectiveness and cost-effectiveness of new and existing medical services and technologies. MSAC has well-proven and robust processes based on internationally accepted health technology assessment principles that are mirrored in the evaluation of medicines by the Pharmaceutical Benefits Advisory Committee (PBAC). Expert advice from MSAC and PBAC is integral to Government decision-making about public funding for medicines, medical services and technologies, with the usual sources of funding being the MBS and the Pharmaceutical Benefits Scheme (PBS). MSAC will continue in this role during the lifetime of the Review, although with a focus on new services.

Medicare and the MBS

The Australian health system overall produces good outcomes for the community. Across the Organisation for Economic Cooperation and Development countries, Australia shares the second-highest life expectancy at birth and has the fourth-highest self-reported health score. While there are a number of drivers of these outcomes, the health system—and Medicare in particular—is a material contributor. Medicare is the Commonwealth-funded health insurance scheme that provides free or subsidised health care services to the Australian population. It was introduced in 1984 as a universal system with the goal of providing Australians with affordable, accessible and high-quality health care.

Services under Medicare include:

- fully or substantially subsidised out-of-hospital (non-admitted) services provided by private practitioners such as general practitioners (GPs), specialists, optometrists and, in specific circumstances, dentists and other allied health practitioners;
- subsidised private patient hospital services;
- fully subsidised hospital treatment for public patients in public hospitals; and
- fully or substantially subsidised medicines through the PBS.

The MBS is a key component of the Medicare system and a key driver of the way health services are delivered in the community. The \$20 billion annual expenditure on the MBS is the largest single health programme funded by the Commonwealth Government, accounting for around 30 per cent of total Commonwealth health expenditure (\$67 billion in 2015–16²). It lists out-of-hospital services provided by private practitioners as well as private patient in-hospital services. It needs to be noted that the MBS has no direct involvement in the provision of public patient hospital services.

The MBS lists services for which patient benefits are paid and allocates a unique item number to each service. There are currently over 5,700 items, each of which has a description of the service (the 'descriptor') and the MBS fee and benefits for that service.

² Commonwealth of Australia, *Budget strategy and outlook, Budget paper no. 1, 2015–16*

The Taskforce acknowledges the contribution of Medicare to achieving Australia’s strong health outcomes and believes that improvements to the MBS will only serve to enhance Medicare and its critical role in the national health system.

Trends in MBS utilisation

Like all parts of the health system, the use of MBS services is growing and at a rate that exceeds population growth. Overall, service volumes increased by almost 20 percent between 2009–10 and 2014–15—from 307.9 million services to 368.5 million—and by over 50 percent since 2004–05. More significantly, per capita use of services has also increased over time, growing from 11.7 services in 2004–05 to 15.4 services in 2014–15, with 89 per cent of the population accessing MBS services.

As expected, the number of services per capita is much higher in the oldest age groups compared to younger cohorts, as shown in Figure 1 below. The per capita use of MBS services in older people is also growing at a faster rate than for younger people. In the over 75 year age cohort, per capita use of services increased from 25.9 to 41.3 between 2003–04 and 2014–15. Figure 1 also shows that even for younger age groups the average number of services per capita is rising. Figure 2 shows service usage by age and gender in a single year, illustrating the different usage by males and females.

Figure 1: MBS services per capita per annum by age: 2003–04 to 2014–15

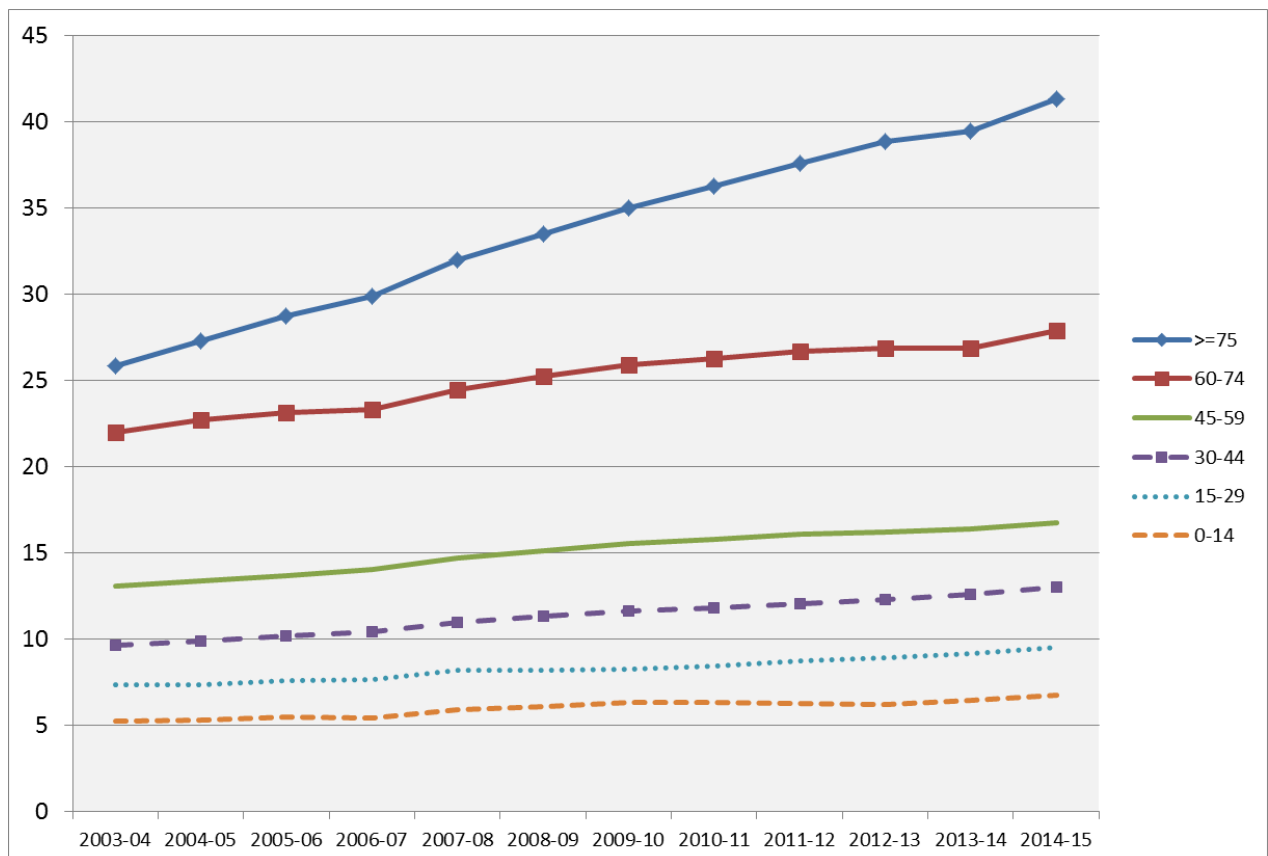
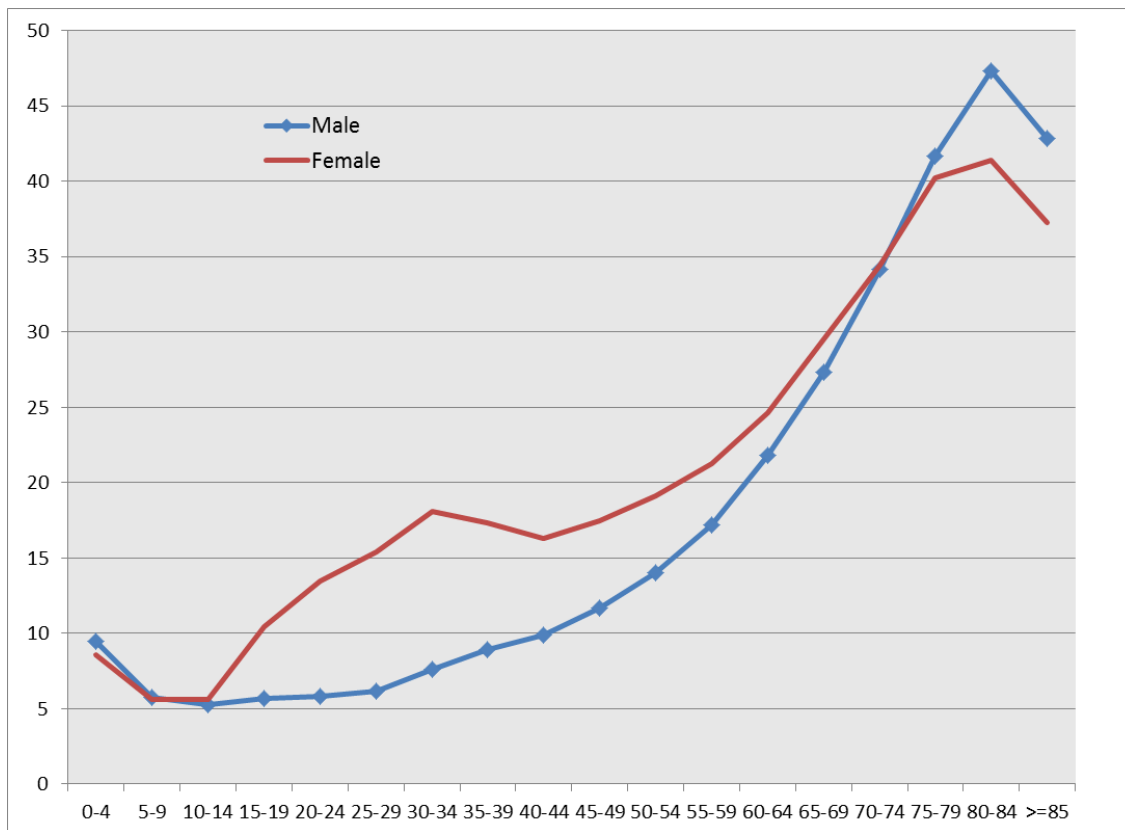


Figure 2: MBS services per capita by age and gender 2014–15



The Bettering the Evaluation and Care of Health (BEACH) report *A decade of general practice: 2004–05 to 2013–14* shows the following breakdown of actions taken by GPs in managing their patients’ problems. In 2013–14, for every 100 patient encounters, there were:

- 49.1 referrals for pathology (an increase from 36.7 in 2004–05)
- 10.9 referrals for diagnostic imaging (an increase from 8.3 in 2004–05)
- 4.9 referrals to allied health (an increase from 2.7 in 2004–05)
- 9.5 referrals to medical specialists (an increase from 7.7 in 2004–05)

This shows not only that referral and requesting behaviour has increased across all these categories, but that one or more of these actions are taken in around 75 per cent of attendances (up from around 55 per cent in 2004–05).

There has been an increase in the proportion of the population that receives a Medicare pathology test annually, up from 46 per cent in 2003–04 to 54 per cent in 2013–14, with the number of pathology services per capita increasing from 3.7 to 5.4 in the same period. The proportion of the population that has a diagnostic imaging service has also increased to 37 per cent from 30 per cent in 2003–04, with the number of services per capita increasing from 2.2 to 2.6.

MBS data can be a useful tool for raising questions about services being provided. Growing utilisation, in the absence of changes in patient need, can be a prompt to consider whether clinically useful items or services are being provided.

Following are examples of cases where MBS data suggested some of the provision of certain MBS services did not reflect best clinical practice and led to the introduction of measures, developed in conjunction with the profession, to address this concern.

- A review of weight loss (bariatric) surgery conducted in 2011 found that surgery is the most effective and cost-effective intervention for managing clinically severe obesity. Various surgical techniques were examined and found to be appropriately safe and effective. That review led to introduction of new MBS items that better described the surgical services then in use. The Government also provided funding to support the roll-out of a Bariatric Surgery Registry which is collecting data that will enable ongoing evaluation of the safety and effectiveness of these procedures.
- The MBS does not fund cosmetic procedures. However there are a number of surgical procedures that in different patients may be used for either a therapeutic or cosmetic purpose. Patterns of use have raised concerns that some of these MBS items are used inappropriately. Safety concerns have also been identified when it is evident that invasive surgical procedures have been performed in unlicensed facilities. Reviews of services such as rhinoplasty, labiaplasty and lipectomy have led to the refinement of item descriptors to clarify the clinical circumstances where MBS payments may be appropriate. In some instances, MBS benefits have been restricted to in-hospital treatment.
- Vitamin D testing was reviewed because of rapidly increasing service volumes—from 117,474 MBS claims in 2003–04 to 4,331,030 claims in 2012–13 (a 3,587% increase). The review found that the majority of vitamin D testing services are undertaken for the purposes of screening rather than diagnosis. Following advice from clinicians, from 1 November 2014, appropriateness criteria were introduced, restricting the payment of MBS benefits to patients at higher risk of vitamin D deficiency. In the period from 1 November 2014 to 31 October 2015, Medicare claims for vitamin D decreased by 30.7 per cent (1.3 million services) compared with the same period in the previous year. This may suggest many GPs have now recognised that this test should only be used for higher risk patients.

WHY DOES THE MBS NEED REVIEW?

When announcing the MBS Review, Minister Ley referred to wide-ranging consultations she conducted soon after taking up office, and the overwhelming support for a review expressed during these consultations. The feedback also revealed a widely- and strongly-held view among clinicians, health professionals and patients that Medicare's structure no longer efficiently supported patients and practitioners to manage chronic conditions or the complex interactions between primary and acute care.

Input to, and support for, the Review has been provided by a wide range of stakeholders, including the Australian Medical Association, specialist medical colleges, provider organisations, individual doctors and other health professionals. Consumer opinion has been widely sought both at general forums and as members of the Taskforce, the Review's Principles and Rules Committee, and Clinical Committees. Of 585 health professionals who responded to the online survey about the MBS Review, 93 per cent agreed that a review of the MBS is needed.

The value in undertaking a comprehensive review of the MBS has been validated by the research and analysis undertaken by the Taskforce, and by reviews of Australian and international health system literature.

In discussions, consultations and analysis, four major issues have been identified as important to consider as part of the Review:

1. MBS Items that are used in a manner that do not reflect contemporary and evidence-based practice. This includes use of outmoded services and in other cases services that do not always provide high-value care.
2. Anomalies in the use of items leading to unwarranted variation, often due to inconsistent interpretation of the item descriptors and/or the MBS rules.
3. Gaps in access to health services, or other distortions in supply, that may be due to the relative value of certain MBS items. This includes both underuse of high-value services and overuse of low-value services.
4. General concerns about the complexity and lack of transparency associated with MBS arrangements.

In deciding to undertake a comprehensive review of MBS, other factors were also considered relevant. These include the following.

The need to optimise high-value care and minimise or eliminate low-value care

Consumers are receiving increasing numbers of services at all ages. The increased use of MBS services would be positive if there was assurance that all of these services provided health benefits to patients, at reasonable cost to the Government and to patients themselves. However, internationally there is concern that patients do not always receive high-value care. It is recognised that even in countries where there is very good access to health care many clinically effective services are underused. It is also accepted that use of these high-value services is to varying extents, displaced by overuse or misuse of low-value health interventions.

Low-value health care has been described as follows:

Low-value care is use of an intervention where evidence suggests it confers no or very little benefit on patients, or risk of harm exceeds likely benefit, or, more broadly, the added costs of the intervention do not provide proportional added benefits. Choosing low-value care consumes resources that could have been expended on alternative forms of care conferring greater levels of benefit, either to the patient in question or to other patients.³

In the MBS context, low-value care includes the use of tests and procedures that are not properly targeted to patients who are likely to derive clinical benefit or are provided to patients for whom the risk of harm exceeds the benefit. There are also MBS services that no longer have any clinical value. These 'obsolete' services have been superseded by better interventions.

Inappropriate use and misuse refer to the use of MBS services for purposes other than those intended. These terms encompass a range of behaviours ranging from failing to adhere to particular item descriptors or rules, through to deliberate fraud.

There is a strong argument that health professionals have an ethical responsibility to avoid waste in healthcare, for two key reasons: firstly, because the resources used wastefully could instead have been used to provide effective interventions for other patients; and secondly because 'useless tests and treatments cause harm'.⁴

One of the Review's key objectives is to maximise the value obtained by current and future MBS funding by reducing the funding directed towards services which do not provide benefits for patients. The obvious way to address this is to ensure, to the greatest extent possible, that services used appropriately are eligible for funding while low-value services are not eligible. There are three recognised indicators of possible low-value care:

1. Where treatments that are proven to be of low or no clinical benefit for individuals with certain clinical characteristics continue to be provided or provided in a sequence which does not reflect best practice.
2. Extreme variation in the provision of care across different settings, where patient characteristics don't provide ready explanation for the variation.
3. Where an otherwise effective test or investigation is performed too often (on the same patient). This category includes the unnecessary duplication of testing because of failure to recognise that it has already been performed recently.

Nevertheless caution must be used in placing too much emphasis on raw utilisation patterns as an indicator of low value. Where an item is used infrequently (or not at all) this may indicate that the item does not reflect contemporary practice or is obsolete. However, even when an item is used rarely, this is not conclusive evidence of obsolescence—it may be that the condition that the item is used for is rare and/or the treatment for that condition is complex and not often provided in the private sector. Examples of the first category include operations for relatively rare congenital disorders such as the repair of bladder extrophy or surgery for exceptionally rare tumours. Examples of the second category include the treatment of major burns or congenital heart disease.

³ Ian A Scott and Stephen J Duckett, *In search of professional consensus in defining and reducing low-value care*, *Med J Aust* 2015; 203 (4): 179-181

⁴ Howard Brody, *From an ethics of rationing to an ethics of waste avoidance*, *N Engl J Med* 2012; 366:1949-1951

Such items need to remain on the MBS for use on the rare occasions they are required. The clinical expertise of the Taskforce and Clinical Committees is indispensable in making these judgements.

The Taskforce has considered Australian and international evidence for low-value care. That literature and the initiatives described below also assisted the Taskforce to identify potentially low-value services and prioritise an initial list of MBS items / topics for review.

Australian and international perspectives—The Choosing Wisely initiative

The *Choosing Wisely* initiative is a notable clinician-led international campaign aimed at eliminating unnecessary treatments, procedures and tests. Originating in the US, *Choosing Wisely* programmes now also operate in Australia and Canada, with similar schemes being established in Germany, Italy, Japan, the Netherlands, and Switzerland. Similarly the EVOLVE campaign led by the Royal Australasian College of Physicians is bringing together medical specialists in a grassroots campaign to identify low-value activities with the goal of positively modifying clinical practice. Cancer Australia has also commenced a *Cancer Statements* initiative in the same vein albeit with an oncology-specific focus.

The *Choosing Wisely* approach is founded on the principles of managing conflicts of interest, improving the quality of care, improving access to care, and promoting the just distribution of finite resources. It brings together clinicians and consumers and considers services which are of questionable value, to inform the decisions of clinicians and to empower consumers to participate in conversations with their doctors about their care.

These initiatives challenge the idea that, in health care, more is always better. One of the challenges with a fee-for-service activity based system like the MBS is that there may be an incentive to provide more services, rather than focus on the outcomes of the service and whether they truly provide health benefit. Activity-based systems, by their nature, can work against ‘watchful waiting’ and other non-interventional approaches to patient management.

In particular, the *Choosing Wisely* methodology involves the compilation—by clinicians—of recommendations about the tests, treatments, and procedures that clinicians and consumers should question. Each recommendation is based on the best available evidence. Of interest, many of these recommendations are common to the Australian, US and Canadian *Choosing Wisely* programmes.

While the kind of information generated by the *Choosing Wisely* approach is an indispensable requirement for meaningful change, it is not the only requirement. Some commentators have noted that information about low-value services alone will not necessarily lead to changes in the behaviour of health professionals⁵ Rather, substantive change requires a multi-faceted approach involving incentives for positive behavioural change as well as the elimination of incentives for the continued provision of low-value care.

Another initiative from the UK, that like *Choosing Wisely* focuses on clinical stewardship as a means to improve the quality and value of health care, comes from the Academy of Royal Medical Colleges. In their 2014 report *Protecting resources, promoting value: a doctor’s*

⁵ Leeder, Stephen, *Evidence alone won’t change what doctors do*, Australian Medicine 27.1 (Nov 2015); 22-23

*guide to cutting waste in clinical care*⁶ the authors closely link waste reduction to higher value care, advocating for clinicians to become ‘responsible stewards’ of the health system.

A doctor’s primary motivation for reducing waste is that it enables the savings to be used more effectively elsewhere. This process creates a higher value health care system where resources: cash, carbon and staff time, are released from some parts of the system to develop new services or support struggling services. Reducing waste in today’s climate of constrained resource is really about creating the health care system that we want to have. It is not just about cutting corners or reducing spending. As responsible stewards, doctors can provide a more effective use of constrained economic and environmental resources.

A cultural shift is required which calls upon doctors and other clinicians to ask, not if a treatment or procedure is possible, but whether it provides real value to the patient and genuinely improves the quality of their life or their prospects for recovery. In other words, don’t do something because it can be done, do it if it is necessary.

The concept of clinical stewardship is not new. Indeed in its submission to the MBS Review, the Australian Medical Association (AMA) commends clinical stewardship as a value that underpins good medical practice and is contained in the AMA’s Code of Ethics.

A clinician-led review enables health professionals to take responsibility for improving the value of health care at a system wide level.

Australian perspective—Over 150 potentially low-value practices: an Australian study

A 2012 study on low-value health care authored by Taskforce member A/Prof Elshaug *et al*⁷ identifies 156 potentially ineffective and/or unsafe services used in Australia.

The study used a multiplatform approach comprising: (i) a broad search of peer-reviewed literature resulting in a total of 5,209 articles being screened for eligibility; (ii) a targeted analysis of databases such as the Cochrane Library and the UK National Institute for Health and Clinical Excellence ‘do not do’ recommendations; and (iii) opportunistic sampling, drawing on the authors’ previous and ongoing work in this area, and nominations from clinical and non-clinical stakeholder groups.

Some of the services identified by this study have been reviewed in Australia under previous processes more limited than the current Review. These include vitamin B12 and folate testing and imaging for low back pain.

Australian perspective—Questionable care: Stopping ineffective treatments

In a 2015 report, the Grattan Institute⁸ suggest that ‘questionable care’ includes two broad categories of treatment. The first is ‘do-not-do’ treatments, which are those treatments where the evidence suggests they should never be provided to a specific type of patient. The second category is ‘do-not-do routinely’ treatments, which are those treatments where the evidence suggests they should only be used in exceptional circumstances or when other options have failed or are inappropriate.

⁶ Centre for Sustainable Healthcare for the Academy of Medical Royal Colleges, *Protecting resources, promoting value: a doctor’s guide to cutting waste in clinical care*, November 2014

⁷ Adam G Elshaug, Amber M Watt, Linda Mundy and Cameron D Willis, *Over 150 potentially low-value health care practices: an Australian study*, *Med J Aust* 2012; 197 (10): 556-560

⁸ Duckett, S., Breadon, P., Romanes, D., Fennessy, P., Nolan, J., 2015, *Questionable care: Stopping ineffective treatments*, Grattan Institute

While the Grattan report focuses on hospital care, three of the ‘do-not-do’ services identified are covered by MBS items. They are:

- arthroscopic debridement for osteoarthritis of the knee ;
- laparoscopic uterine nerve ablation for chronic pelvic pain; and
- removing healthy ovaries during a hysterectomy.

The report found that these treatments are being provided in higher numbers than the evidence suggests they should be, and often to patients who should not receive them. There is also significant variation in their provision between the States and Territories.

The report also classifies as ‘do-not-do’ two treatments which were, on the recommendation of MSAC, either removed from the MBS or amended to exclude certain clinical indications. These treatments are:

- vertebroplasty for osteoporotic spinal fractures (MBS items removed 1 November 2011); and
- hyperbaric oxygen therapy (item descriptor amended to remove coverage of chronic non-diabetic wounds 31 October 2012).

Australian perspective—The Australian Commission on Safety and Quality in Health Care Australian Atlas of Healthcare Variation

Another potential indicator of low-value service provision is marked variation in the per capita use of services provided in different geographic areas—even for services whose efficacy is not generally open to question, including common surgical procedures. It can be difficult to determine the cause of these variations and on which side of the relationship any anomalous practice is occurring—that is, whether the patients in the high-use area are receiving too many services, or the patients in the low-use area are receiving too few, or both if both are occurring simultaneously, or neither.

The Australian Commission on Safety and Quality in Healthcare’s *Australian atlas of healthcare variation* published in November 2015 provides much information about the relative use of some common tests, procedures and therapies. The Atlas is available at: www.safetyandquality.gov.au/atlas/

The introduction to the Atlas notes: ‘Some variation is expected and associated with need-related factors such as underlying differences in the health of specific populations, or personal preferences. However, the weight of evidence in Australia and internationally suggests that much of the variation documented in the Atlas is likely to be unwarranted. Understanding this variation is critical to improving the quality, value and appropriateness of health care.’⁹

The Atlas describes such variations for a range of services covered by the MBS. Notable examples of include:

- Nearly 600,000 MBS-funded colonoscopies were performed in Australia in 2013–14. Very large variations were seen across the country – the area with the highest rate was 30 times higher than that of the area with the lowest rate.

⁹ Australian Commission on Safety and Quality in Healthcare, *Australian atlas of health care variation*, 2015

- In 2013–14, 314,000 MBS-funded computed tomography scans of the lumbar spine were performed with marked variation across the country. The number of services was 11.8 times higher in the area with the highest rate compared to the area with the lowest rate. Inappropriate use of this diagnostic imaging exposes patients to unnecessary radiation.
- Rates of MBS-funded knee arthroscopy in people aged 55 and over were seven times higher in some areas of Australia than in others. Evidence suggests that knee arthroscopy is of little benefit for older people with osteoarthritis, and may in fact cause harm.
- Women living in some regional areas of Australia were up to five times more likely to undergo a hysterectomy or endometrial ablation for abnormal uterine bleeding than those living in cities.
- Patients in some areas of Australia were seven times more likely to undergo MBS-funded cataract surgery than those in some other areas, with more than 160,000 operations recorded in 2013–14.

The Atlas includes key findings and recommendations for further action; a number of recommendations are directed to the Taskforce, including:

- That the Taskforce reviews relevant MBS item/s to align reimbursement with adherence to the existing National Health and Medical Research Council clinical practice guidelines for surveillance colonoscopy.
- A recommendation to the Taskforce that, given the lack of clinical evidence for the efficacy of knee arthroscopy for people with degenerative changes in the knee, the relevant MBS item/s be amended to remove knee arthroscopy for this group.
- That the Taskforce reviews the relevant MBS item/s for cataract surgery to require adherence to an applicable Clinical Care Standard for the surgery.

Patients cannot always access the services they need

The evidence, including patient experience as reported in the Review consultations, indicates that the MBS is performing relatively well in facilitating access to GP services, but less well in relation to specialist services.

There is increasing evidence that Medicare has been largely successful in reducing inequity in the use of primary medical care, with low socioeconomic groups using general practice and public hospital services more frequently than high socioeconomic groups (as is appropriate to need). The overall effect of Medicare has been to reduce differentials in use of primary health care and we should acknowledge and protect these achievements at the same time as seeking to make further improvements. The picture is far less positive for specialist care and dental care.

Although medical specialist care including imaging is reimbursed through Medicare, the average size of co-payments over and above the Medicare rebate has increased over the past 20 years. Patients on low incomes are less likely to see a specialist than those with

higher incomes. Inequities are exacerbated by the workforce distribution, with worse access in rural areas.¹⁰

Analysis of 2013–14 MBS data at the Primary Care Network level demonstrates that MBS expenditure on GP visits ranged from \$203 per capita in the Australian Capital Territory to \$339 per capita in South Western Sydney. MBS expenditure on specialist visits ranged from \$43 per capita in Northern Queensland to \$114 per capita in Northern Sydney. Unlike expenditure on GP services, per capita expenditure on specialist visits is highest in the most advantaged areas of Australia.

The system lacks transparency and MBS data are underused

A recurring theme in stakeholder feedback has been the need to better use MBS data both for directly clinical reasons and for research, and the Taskforce strongly supports this approach. The Taskforce also supports more systematic linking of data, particularly MBS and PBS data and especially where it supports these clinical and/or research objectives.

The monitoring of MBS activity by the Commonwealth Departments of Health and Human Services generates a great deal of data in a range of areas, including:

- the utilisation of individual MBS items and the benefits paid, both on a broad, population-based level and also in relation to specific episodes of care;
- MBS utilisation by particular groups of providers and in particular fields of practice;
- the MBS claiming and billing patterns of individual practitioners, including bulk billing rates and out-of-pocket charges; and
- the geographical distribution of MBS activity.

These data allow analysis of long-term trends, modelling of future activity, and the monitoring of individual provider behaviour for compliance purposes. Importantly, the data also allow the examination of specific services—not only their use in isolation, but also in conjunction with other services and their role in current medical practice.

What these data do not capture is the clinical reason for the provision of many MBS-funded services. The Taskforce will give consideration to whether there is utility in better capturing clinical data and if so can this be done without creating an additional administrative burden.

Moreover, MBS data are not readily linked with data from other components of the health system, including the PBS and hospitals, limiting the ability to understand how groups of patients interact across the different elements of the health system.

The potential value of MBS data and other information to consumers is also not being fully exploited. Better access to data may assist consumers both in accessing care in the first instance, and also making decisions about their subsequent care. In particular, the Taskforce notes that there is support for improving information to patients about fees charged by healthcare providers.

The MBS rules are complex and applied inconsistently

The MBS is underpinned by legislation and regulation that supports the goal of providing universal access to safe, cost effective and clinically appropriate health professional services.

¹⁰ Harris, Mark F. *Who gets the care in Medicare?* MJA 197 (11/12); 598-599

Regulation also ensures that the financial integrity of a \$20 billion taxpayer funded programme is protected.

Over time, these rules have become increasingly complex and are often applied inconsistently by providers and the administrators of the system. This means that some patients may receive quite different MBS rebates even though they have received the same professional service. In other instances, the rules (or the way they are interpreted) work against providing efficient health care. Health professionals have little formal education about the rules and may rely upon their peers for advice about interpretation. To some extent this may provide the explanation for the variation in the use of some MBS items.

METHODS: THE APPROACH TO THE REVIEW

This section describes the arrangements the Taskforce has put in place to commence the Review and also to trial and refine the methodologies which will be used for the major part of the Review's work throughout 2016. Considerable thought and intensive consultation have gone into the development of the arrangements described below, and while there may be some fine-tuning it is not anticipated that any radical changes will be made to these basic structures and processes. Rather, further work in this area will be in ensuring that effective administrative and policy support mechanisms are in place to measure and optimise the performance of these structures and processes.

Given the scale of the Taskforce's remit, much of the discussion at its early meetings focused on approaches to prioritising areas of the MBS for review, and on the mechanisms by which reviews might be carried out. A strategy for achieving appropriate stakeholder and broader community engagement throughout the review process is also high on the Taskforce's agenda.

With regard to its general approach, the Taskforce identified five main reasons for making changes to the MBS, with the overarching objective of maximising the value obtained by the community and the health system as a whole from health expenditure:

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

The Taskforce is also mindful of three key issues that inform its deliberations:

- the potential impact on patients;
- the potential impact of its recommendations on the viability of private sector health businesses (and any resulting impact on access to services); and
- the need to minimise the introduction of new regulations and 'red tape'.

Clinical Committees

The Taskforce decided that for the Review to deliver a contemporary, high-value MBS, clinician involvement was critical. The core of the methodology that has been established for the Review uses discipline specific clinical committees, along the following processes:

- Establishment of Clinical Committees that are allocated a defined range of current MBS items to review and are composed of a mix of clinicians who are expert in providing those services, clinicians who practise in a related area, generalist expertise, a consumer representative where relevant, and any other relevant skills. Clinical Committee members are selected by the Taskforce from nominations and with regard to advice from professional bodies.

- Members of Clinical Committees are appointed in their individual capacity, not as representatives of their professional or other organisations. This aims to ensure that health professionals and the wider community have confidence in the integrity of the process and its outcomes.
- Clinical Committees will be chaired by a clinician, selected by the Taskforce, who is expert in the discipline that provides the relevant services.
- Clinical Committees will be expected to take account of recent evidence relevant to their field, and to frame their recommendations with reference to this evidence.
- Clinical Committees may establish Working Groups to conduct reviews of a particular item or items, and the composition of Working Groups should reflect the same principles.
- Clinical Committees and any Working Groups will be supported by secretariat services, data analysis and policy advice provided by the Department of Health, or by consultants or contractors procured by the Department of Health.
- Where a review of relevant evidence is required to support a Clinical Committee or Working Group, this support will be provided through the Department of Health.
- Clinical Committees will provide to the Taskforce recommendations about each item in their allocated range, including recommendations for changes or recommendations that changes are not required. Where changes are recommended, Clinical Committees must identify the evidence used to support the recommendation.
- Clinical Committees may also make recommendations about how existing MBS rules and legislation affect items in their remit.
- All changes are to be subject to consultation with relevant stakeholders, including health professionals and consumers, prior to such recommendations being submitted to the Minister by the Taskforce.

Clinical Committee goals

The work programmes of Clinical Committees will generally include the following elements.

- *Identifying obsolete items*
As an initial step, Committees review allocated MBS items to determine if any of those services are obsolete—that is, clinically inappropriate in all circumstances—and could be removed from the MBS.
- *Individual item review and prioritisation*
Committees review allocated items to determine which require a detailed service level review. These items are prioritised and, if necessary, referred to a Working Group/s. The Taskforce may provide guidance about prioritisation. Working Groups are provided with a carefully targeted list of research questions and/or issues.
- *Consideration of item descriptors*
Allocated items are reviewed to determine whether the item descriptor satisfactorily describes the service—that is, describes the necessary components of the service in a clear, coherent way that is reflective of contemporary best-practice and minimises the potential for variation in billing practices for the same service.

The rapid review process

In some cases, the review of MBS items will require an evaluation of the evidence for the relevant service's safety and/or clinical effectiveness and/or cost effectiveness. The sheer scale of the MBS Review and the need to efficiently use the time and skills of many clinicians means that a consistent, standardised approach to the evaluation of evidence is required. In the first phase of the MBS Review a specific methodology used successfully in Ontario, Canada—the 'rapid review'—is being trialled. The *Health Quality Ontario (HQO) Appropriateness Initiative* has many features that are similar to the processes used by MSAC and the Department of Health's reviews of various MBS services over the past several years. There are key differences that aim to streamline the process to meet accelerated timeframes while ensuring that the evaluation of evidence is sufficiently robust. Most importantly the correct research question needs to be developed early on and the relevant Clinical Committee needs to be committed to concluding a review within a few meetings.

Principles and Rules Committee

The Taskforce established the MBS Principles and Rules Committee to advise on matters related to the legislation and regulation underpinning the MBS, as well as other non-clinical issues pertaining to the broader design and structure of the MBS. This Committee is chaired by Taskforce member Professor Michael Grigg and, similarly to the Clinical Committees, has broad-based clinical membership. Stakeholders have identified MBS rules where the intention of the rule is not always clear and the application is variable. Reducing the complexity of the MBS and ensuring alignment of the rules with the purpose of the MBS will be key goal of the Review.

Some specific examples of the types of rules the Principles and Rules Committee will examine include those pertaining to:

- referrals between medical practitioners;
- the co-claiming of consultation items with procedural items for a single episode of care; and
- multiple services rules e.g. multiple operations rules, diagnostic imaging services rules and pathology coning.

New services

The Taskforce's Terms of Reference do not preclude it from recommending that new items or services be added to the MBS. Where the Taskforce does recommend new items, the Minister will determine whether to seek advice from MSAC, depending on what kind of change is involved. For example:

- An existing item or items might be combined to form a new item or items that better describe an existing service. While this might look like a new item, it will in effect be just a better description of an existing service. There would seem to be little benefit from MSAC reviewing this kind of change, as the patient group and clinical and cost effectiveness should not have changed.
- Where good clinical practice requires the addition of a service not effectively captured by the MBS, the Minister might ask MSAC for expedited advice.
- Where a proposed new item is for a completely novel treatment or technology,

the Minister might choose to ask for a full MSAC review of the evidence.

In relation to the second category, the fact that the relevant Clinical Committee or Working Group will have already identified the key clinical questions and been supported to identify relevant evidence, will reduce the amount of time required for MSAC consideration.

Review of rebate value

The Taskforce is still considering its approach to reviewing the value of MBS items, noting the challenge of estimating the effects of changes on consumers and health care providers. At this early stage of the Review, the Taskforce proposes to guide Clinical Committees that it would be appropriate for them to recommend consideration of changes to the existing value of MBS items in the following circumstances:

- Where there is evidence that current pricing is distorting service provision (either encouraging over-servicing or under-servicing) and that a change to fee relativities is likely to address this distortion and lead to measurable positive impacts on patients.
- Where a new item is recommended to replace existing items, for example through 'bundling'.
- Where a Clinical Committee considers that some items in its range have pricing that is significantly inconsistent with relative costs, it may recommend changes to smooth relativities, with an expectation that expenditure in the area will remain similar.
- Where pricing for an item recognises capital costs, consumables, costs of other staff, or other components beyond the professional service, Clinical Committees should consider whether such additions should apply only where there is clear line of responsibility for those costs to the professional providing the service.

Any broader review of rebate values will not be undertaken until a robust methodology is developed in the latter part of 2016.

Pilot Clinical Committees

In late 2015, the Taskforce performed an initial high-level review of the MBS and identified areas for early review based on the literature, safety concerns, putative low value, profession or consumer interest, or MBS usage data. The first five Clinical Committees have been established and deliberations are well underway. These Committees will test the Review's proposed processes:

- Diagnostic Imaging Clinical Committee (priority reviews of bone densitometry, imaging for pulmonary embolism and acute deep vein thrombosis, and imaging of the knee)
- Ear, Nose and Throat Surgery Clinical Committee (priority reviews of tonsillectomy, adenoidectomy and grommets)
- Obstetrics Clinical Committee
- Thoracic Medicine Clinical Committee (priority reviews of sleep studies and respiratory function tests)
- Gastroenterology (priority reviews of upper and lower GI endoscopy)

An outline of the work of the initial Clinical Committees, as well as the specific MBS items for which each Committee is responsible, is provided at Appendix A. Between them, these Committees have responsibility for almost 1,100 MBS items—just under 20 per cent of the total number. Because of the concurrent work of PHCAG, the Taskforce has decided that its review of GP and allied health services should be deferred until later in 2016. The Taskforce is not making any recommendations based on the work of its Clinical Committees in this report, as public consultation has not yet taken place.

Conflicts of interest

Some stakeholders have raised concern about whether health service providers who earn an income partly based on Medicare rebates will be able to provide unbiased advice. Others have raised concern that excluding those who provide Medicare-eligible services in an area under review would mean that those with the most expertise, in current service provision, evidence, and how current MBS arrangements work in practice, would not be heard, and therefore the Review would be less likely to reach appropriate recommendations.

The Taskforce has decided that clinicians currently providing Medicare-eligible services should be included in clinical committees and that the chair of a Clinical Committee should be such a clinician. There are a number of other aspects of the Review process that have been put in place to reduce the risk:

- All Clinical Committees have broad membership. Each Clinical Committee will be chaired by a clinician practising in the area and include other clinicians from that discipline, as well as a number of clinicians who practise in different fields as referrers of services, and where relevant, consumers and health technology experts. It is anticipated that generalists and, in particular, general practitioners will participate in most groups.
- Clinical Committees and Working Groups are directed to refer to available evidence and to reflect the identified evidence in their reports to the Taskforce.
- All members of the Taskforce, Clinical Committees and Working Groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically.
- Recommendations from Clinical Committees will be subject to broad public consultation before the Taskforce makes any recommendation to the Minister.
- There is a member of the Taskforce on each Clinical Committee who is not a member of the craft groups using the item numbers under discussion.

Consumer engagement

The Taskforce considers that involving health care consumers and the public in the Review process is integral to the process of review and that in addition, the Review presents an opportunity to trial and evaluate different approaches to consumer engagement. While some Clinical Committees will include one or two consumer representatives, for other areas different approaches to consumer involvement will be tested. The consultation process for draft recommendations will also involve seeking the views of relevant consumer organisations.

The Taskforce has received advice from consumer involvement experts that an effective model for having consumers provide meaningful input to the Review would have the following characteristics:

- Clinical Committees would aim to have two consumer representatives, one a patient representative, the other a public representative.
- Either in addition to or as part of the patient representative role would be a consumer liaison role, specifically tasked with facilitating input from a broader range of patients.
- A specific consumer sub-committee should report to the Taskforce. This group would facilitate and provide the patient and public perspectives on overall recommendations.

The Taskforce is considering this advice and will decide which elements to incorporate or trial at its next meeting.

Ongoing MBS review

Consistent with its Terms of Reference, another key project for the Taskforce will be the development of strategies and mechanisms for the ongoing review of the MBS once the current Review is concluded. This will be critical to maintaining the ongoing currency of the MBS.

The Taskforce has significant expertise at its disposal to progress this work, and insights gained from the Review itself will inform the process. It is anticipated that the Taskforce will focus on this issue later in 2016, when more substantial experience with and lessons from the Review have been accrued and can be fully exploited.

PRELIMINARY RESULTS AND CONSIDERATIONS

Public consultations—Overview

The views expressed in the Minister’s consultations have been reinforced in extensive public consultations undertaken by the Taskforce soon after its formation. Stakeholder forums were held in Canberra (8 July 2015), Adelaide (24 July), Perth (25 July), Melbourne (27 October) and Sydney (3 November). Over 80 organisations and 256 individuals participated.

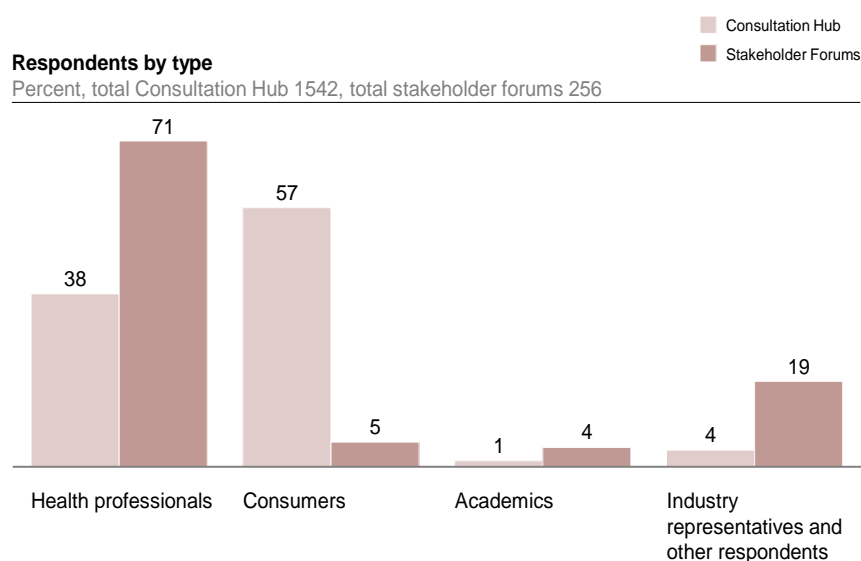
In addition, an online public submissions process was conducted over six weeks from 27 September to 9 November 2015 through the Department of Health’s Consultation Hub, inviting responses to an online survey as well as written submissions. To support this process, the Taskforce released two consultation papers: one paper aimed at an audience with a professional interest in, and some familiarity with, the MBS (Appendix C) and a condensed version of this paper intended for consumers of MBS services. Figure 1 below shows a breakdown of the participants in the forums and online survey.

There were 1,541 responses to the online survey and 240 written submissions. Significantly, in the online survey health professionals were asked, ‘Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?’ Of 585 health professionals who responded to the survey, 93 per cent answered ‘yes’ to this question.

Many health professionals provided in-depth feedback on individual MBS items or groups of items. Broadly, feedback highlighted four types of issues associated with current MBS items: overuse of low-value services, underuse of high-value services, obsolescence, and misuse. Approximately 300 health professionals provided specific examples of low-value and high-value usage through the online survey, as well as examples of obsolete items or misuse.

Additionally, the stakeholder forums in Sydney and Melbourne identified 32 examples of low-value usage, 14 examples of high-value services, 19 examples of obsolete items and three examples of items allegedly being misused.

Figure 3: Participants in Taskforce consultations July–November 2015



A report at Appendix B describes in detail the feedback received through the stakeholder forums and online survey. It must be stressed that this material simply reports the feedback obtained, and does not represent the views or intentions of the Taskforce. Many of the issues raised will require further examination by the Taskforce, Clinical Committees and the Principles and Rules Committee.

Public consultations—Issues identified

The following discussion summarises the more detailed report on stakeholder consultation at Appendix C and as such reflects feedback received through stakeholder forums and the online survey conducted between 27 September and 9 November 2015. The more than 240 formal submissions received will be analysed separately. In addition those submissions will be provided to the relevant clinical committees to inform their work. The providers of submissions are listed at Appendix D.

MBS rules and regulations

Health professionals and consumers reported that current MBS rules can at times impede the delivery of patient care. Overall, 67 per cent of health professionals who responded to the online survey believe that MBS rules and regulations need to be reviewed—either for the whole of MBS, for individual items, or for both.

Consumers similarly reported difficulties with MBS rules. Over 60 per cent of consumers respondents reported encountering difficulties with Medicare rules. Of the 553 responses identifying rules or areas where consumers had faced difficulties, 400 related to mental health.

Rules-based issues that were raised repeatedly in both stakeholder forums and the online survey included referrals, MBS fees and prices, service limits, and the range of eligible providers. The Principles and Rules Committee will be asked to consider the concerns raised.

Design of gatekeeper and referral arrangements

Responses on these topics commonly focused on two scenarios: where the gatekeeping function of referrals was seen as unnecessary, or where systems for repeat referrals wasted time and resources.

In relation to the first concern, many health professional respondents argued that referrals through GPs were unnecessary, particularly when accessing allied health services. It should be noted that the prevalence of this issue may reflect the skew towards allied health providers in the health professional respondent group. Consumers also argued that requiring a GP referral to access mental health services could act as a barrier to treatment. Additionally, a number of respondents, both health professionals and consumers, reported that the three-month limitation of specialist to specialist referrals was inconvenient and unnecessary.

MBS fees and benefits

Health professionals and consumers frequently raised issues with MBS fees and benefits. While health professionals tended to be concerned about MBS fees relative to other services or providers, consumers were generally concerned about the financial pressure caused by high fees and gaps.

Issues with affordability were commonly cited in relation to specialist services. While many consumers reported that the MBS adequately provided for everyday GP visits, specialist care was often considered unaffordable.

Service limits

Service limits apply to some MBS items to restrict the number of MBS-funded services within a particular period of time. These include a five session limit per calendar year for allied health services under chronic disease management plans, and a ten-session limit for psychology appointments. Service limits were the most frequently raised MBS rule by consumers, with over 300 consumers referring to the difficulties they faced once their annual allocation of appointments with psychologists and other allied health providers had been exhausted.

Providers and scope of practice

The range of MBS-eligible providers and their scope of practice raised by health professionals, particularly those contributing through the Consultation Hub. Again, this reflects the high proportion of allied health professionals in Consultation Hub responses. By far the most prevalent concern was that allied health professionals or nurses should be able to perform a greater variety of MBS services, including providing referrals to specialists or requesting diagnostic tests.

Clinician and practice benchmarking

There has been widespread support for reinstating some form of benchmark reporting on MBS item usage. This was historically performed by DHS but ceased some years ago. This allows an individual clinician or practice to see how their usage of particular items compares with the national average.

Using the MBS

A common frustration with the MBS system voiced by both practitioners and consumers was that necessary information was often unavailable or difficult to access. These concerns fell into three areas: the lack of transparency surrounding MBS usage; variation and prices; information on MBS rules and regulations; and information required by consumers to empower them in making decisions about their own healthcare.

Transparency

Transparency surrounding usage, variation and fees was the second most commonly cited priority area for review at the Sydney and Melbourne stakeholder forums, with 45 per cent of participants ranking the issue in their top five issues for the Taskforce to review. Stakeholders suggested that more transparent information would assist health professionals in evaluating their own clinical practice.

Broader shifts in the MBS and its administration

A number of respondents raised concerns with the type of treatment currently incentivised by fee-for-service funding. This issue was initially raised in the July stakeholder forums as one of the overarching changes required for a successful MBS Review. Through the Consultation Hub, many respondents commented that the current system encourages volume, and financially rewards practitioners who carry out more investigations and medical interventions.

Complementing the MBS with outcomes-based reimbursement was the third most commonly cited issue at the stakeholder forums, with over 40 per cent of respondents placing it in their top five issues. However, respondents were at pains to emphasise that outcomes-based reimbursement should support existing MBS fee structures in appropriate

areas, rather than replacing fee-for-service medicine. The role of outcomes-based payments in primary care is being considered by PHCAG.

DISCUSSION AND NEXT STEPS

A number of key issues for the Taskforce's particular attention have been identified through its own deliberations as well as through stakeholder feedback. These issues are discussed briefly below and will be considered more fully as the Review progresses.

Greater transparency

Better and more readily available MBS information and data would assist consumers of MBS services in making decisions about accessing services. In particular, the Taskforce supports greater fee transparency.

Health professional audit and feedback

The Taskforce also endorses the view that health professionals should receive data about their own use of MBS funded services relative to their peers. Feedback is an important quality assurance mechanism that supports good practice.

An emphasis on outcomes rather than activities

Although a system that is more outcomes-focused is desirable, any such change to the MBS would require careful consideration. The evidence suggests that clinically based outcomes linked to payment have mixed success and may not be superior to activity based payments in driving high-value care. Indeed the MBS itself has many examples where incentive payments directed to addressing service deficits have had undesirable outcomes. The preliminary view of the Taskforce is that the evidence base for specific proposals would need to be carefully examined and their likely impacts identified.

Supporting multidisciplinary care

Many stakeholders have suggested that, with its fee-for service structure, and the resulting emphasis on discrete activities and short-term episodic care, that the MBS continues to reflect the more isolated type of medical practice that was prevalent at the time of the MBS's introduction. This structure does not best support the integrated, multi-disciplinary care which is now recognised as integral to the long-term care of patients with complex conditions. While this is a focus of the work of PHCAG, the Taskforce will also consider whether there are opportunities to complement the fee-for-service MBS system with other payment elements, such as those linked to outcomes, bundling a number of services into evidence-based episodes of care, or reflecting integrated care processes.

Interim MBS items

As noted above, in response to concerns raised by stakeholders, the Minister clarified that while the focus of the Taskforce is on existing items, its Terms of Reference do not preclude it from recommending that new items or services be added to the MBS.

The Taskforce has also discussed the possibility of recommending the addition of temporary item numbers to be used specifically for the acquisition of evidence to support the long term retention or removal of items from the MBS. Participation in trials of new treatments or diagnostic procedures would be subject to standard ethics approval and recommendations from the National Health and Medical Research Council after a review process. This will be the subject of further modelling and consultation.

Better compliance

Minimising both deliberate and inadvertent misuse of MBS items is necessary to protect the integrity of the MBS. Clarifying rules and providing better information, education and feedback to clinicians should go some way to improving compliance.

A cautious approach to the removal of MBS items

The Taskforce recognises that low usage of an item is not in itself conclusive evidence of obsolescence, and will rely on expert clinical advice and stakeholder consultation when developing recommendations in this area.

Evaluating the effectiveness of the Review

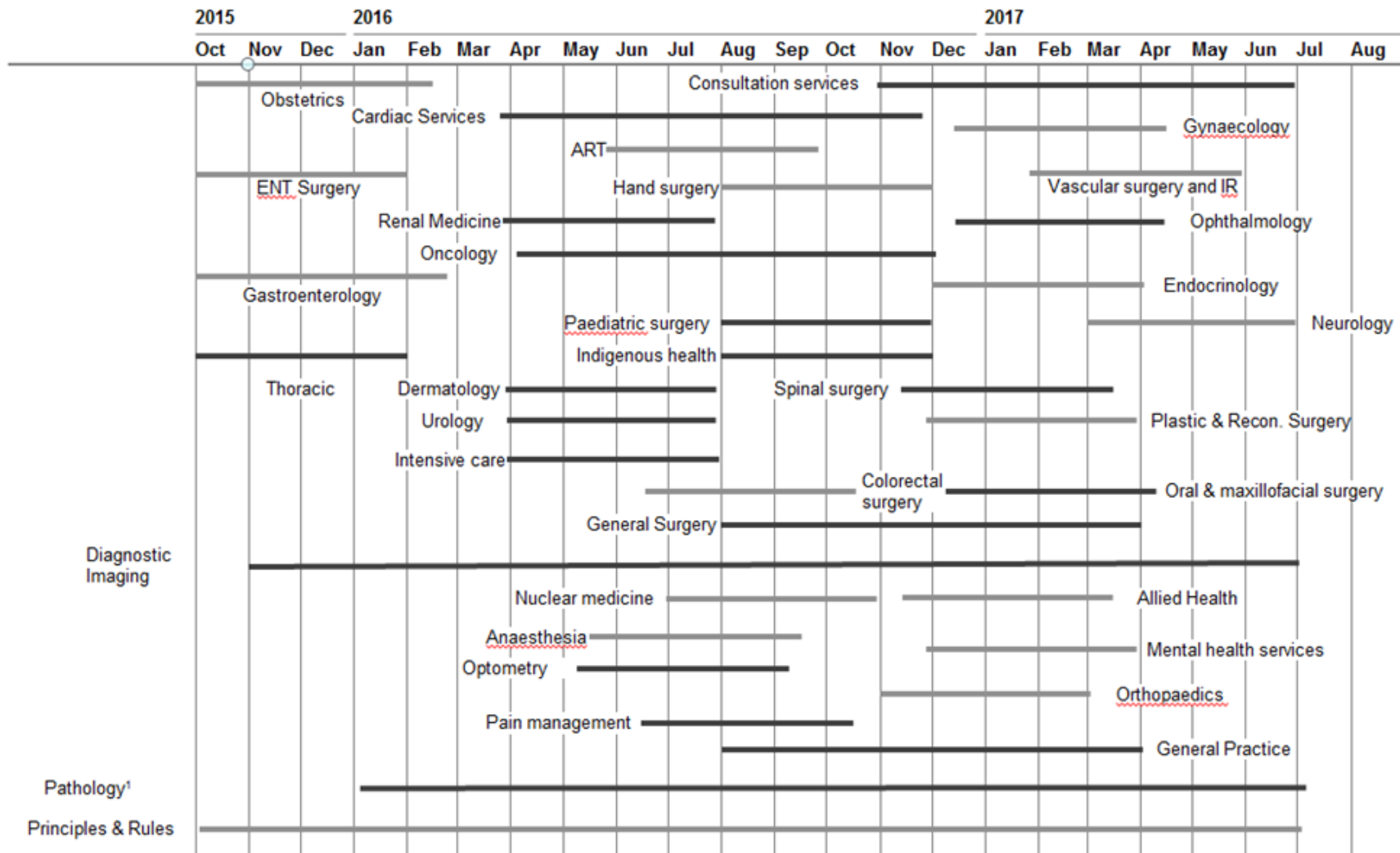
Measuring and monitoring the effectiveness of the Review will be important for ensuring continuous improvement to review methods and demonstrating the benefits of the Review. One important source of evidence is feedback from the clinicians and others directly involved in Clinical Committees and the responses to stakeholder consultation, as reflected above.

As the Review progresses to recommending specific changes, these can be subject to monitoring and data collection to establish whether they are achieving the intended outcomes. Clinical Committees will play an important role in identifying sources of information beyond MBS data.

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PROVISIONAL WORK PROGRAMME FOR 2016

The diagram below sets out the proposed timelines for the various Clinical Committees to be active in 2016.



Ongoing stakeholder engagement

In 2016 the Taskforce intends to increase its consultation with stakeholders through forums, focus groups, further public submissions processes and other mechanisms including presentations and Q&A sessions by the Taskforce Chair and other members as opportunities arise. This consultation will be supported by clear communications of progress via professional and consumer groups as well as various media outlets.

The Taskforce itself is predominantly composed of medical professionals and engagement with medical stakeholders will continue to be a high priority. In particular, the Taskforce intends to engage more closely with medical colleges. The Taskforce also considers that broader engagement, with allied health and nursing professions, academics, health consumers and the public, is also critical.

Clinical Committees

As noted above, five Clinical Committees and the MBS Principles and Rules Committee have met and commenced their work programmes. These committees were given priority because of the issues which fall within their remits. These issues were identified by the Taskforce either as being, in the case of the Principles and Rules Committee, of importance to the conduct of the Review and, in the case of the Clinical Committees, issues which offered opportunities for early results.

It is also part of the role of these committees to trial Review methodologies, and several important lessons have been learned to date. One such lesson relates to the challenge of engaging the number and range of health professionals and other relevant stakeholders to participate in Clinical Committees—although it must be said that the response from persons approached for this purpose has been uniformly positive. There is evidence of a widespread perception that this Review offers a unique opportunity to influence real and long-term improvements to the MBS.

The Taskforce has identified the Committees which will comprise the second tranche of Clinical Committees:

- Pathology (including priority reviews of blood transfusion services, iron studies, coagulation studies)
- Oncology (includes medical oncology and radiation oncology)
- Dermatology, allergy and immunology
- Endocrinology (includes endocrine surgery)
- Renal medicine
- Intensive care and emergency medicine (includes neonatology)
- Cardiac services

A significant challenge is presented by the level of resources needed to support the various Review Committees and the Taskforce. This challenge is set to increase as, in addition to the 12 Committees identified so far, over 20 more will be required to cover the full range of MBS items. At this stage, the anticipated list of additional Committees comprises:

- Allied health (includes currently funded chronic disease management services)

- Anaesthesia
- Colorectal surgery
- Consultation services (includes specialist and consultant physicians)
- General practice (includes health assessments and acupuncture)
- General surgery (includes abdominal, upper gastrointestinal surgery)
- Gynaecology
- Hand surgery
- Indigenous health
- Mental health services (includes psychiatry and GP mental health items)
- Neurology (includes neurosurgery and interventional neuro-radiology)
- Nuclear medicine
- Ophthalmology
- Optometry
- Oral and maxillofacial surgery (includes the Cleft Lip and Cleft Palate scheme)
- Orthopaedics
- Paediatric surgery
- Pain management
- Plastic and reconstructive surgery
- Spinal surgery
- Urology
- Vascular surgery and interventional radiology

Ongoing challenges

While it is intended that the bulk of the Review's work will be completed in 2016, this will require a staged rollout of committees. The relevant processes, including interactions between the Taskforce, Principles and Rules Committee and existing Clinical Committees (and Working Groups), will be refined over time and become more easily managed with the benefit of experience.

A key risk in this regard is a loss of momentum and a failure to capitalise on the current high levels of enthusiasm and commitment shown by stakeholders, particularly clinicians. Their close engagement is obviously crucial, and if the Review appears to be flagging with outputs falling below expectations, it will become increasingly difficult to secure this engagement.

At the same time, it will be important to strike a balance between maintaining stakeholder engagement by demonstrating real progress through, for example, circulating draft recommendations early and regularly, and ensuring that the processes and resources are in place to ensure that stakeholders feel they are participating in a well-designed and well-supported venture.

APPENDICES

APPENDIX A – Clinical Committees

APPENDIX B – Summary of stakeholder forum and online survey consultations

APPENDIX C – Public Submissions Consultation paper

APPENDIX D - Providers of submissions 2015

FIRST TRANCHE OF CLINICAL COMMITTEES

Clinical Committee deliberations

The following sections summarise the issues considered by the Review's first Tranche of Clinical Committees and some early views formed by the Committees.

Part of the Committees' remit was the nomination of potentially obsolete MBS items which should be removed from the MBS. All draft recommendations arising from the Review, including draft recommendations on these items, are submitted for public consultation in line with the Taskforce's commitment to a consultative, transparent process. Other matters discussed here form part of the workplans of the relevant committees and have not yet been the subject of consultation.

The Committees nominated MBS items which are potentially obsolete according to the following definition:

Obsolete items are items for services which have no clinical purpose in contemporary practice, are better covered under other items, or items which are no longer used for the purpose for which they were introduced.

The items identified so far are:

- *Diagnostic imaging*
 - 58706, 58924, 59503, 59715, 59736, 59760, 61465
- *Ear, nose, and throat surgery*
 - 11321, 18246, 41680, 41695, 41758, 41761, 41846, 41849, 41852
- *Gastroenterology*
 - 13500, 13503, 30493, 32078, 32081
- *Obstetrics*
 - 16504
- *Thoracic medicine*
 - 11500

On 21 December 2015, draft recommendations on these items were released for stakeholder consultation on the Department's online consultation tool. Information about the consultation process was sent directly to individuals and organisations which have engaged with the Department or the Taskforce on the Review, although the consultation is of course open to all interested parties. The information provided stressed that the draft recommendations do not represent a final position on these items and that, following the consultation, they will be subject to further consideration by the relevant Committee, the Taskforce and, where the Taskforce makes a recommendation, by the Government.

The list of MBS items allocated to each of the initial Clinical Committees is provided after the outline of their early considerations.

Gastroenterology Clinical Committee

Overall progress

The Gastroenterology Committee is expected to finish and endorse a draft review report for the priority reviews topics of colonoscopy and upper GI endoscopy by early 2016 for Taskforce consideration prior to stakeholder consultation.

The Committee has identified a number of issues for noting in its review report which have broader application across the MBS and should be considered by the Taskforce including the implications of including high cost consumables in the item fee for services performed in out-of-hospital settings and advice on the construct of an item descriptor and the use of appropriateness criteria.

The Committee has signalled that action should be taken to address financial misuse of the MBS (e.g. co-claiming of additional MBS services which should be considered part of the service and have financial implications for patients) with amendments to be recommended to item descriptors. It will also recommend amendments to an item for capsule endoscopy to better defining patient indications.

Priority reviews—Colonoscopy—Preliminary findings

The Committee was not of the view that MBS data showed that rates of repeat colonoscopy nationally were necessarily excessive. However, the Committee has identified a lack of specificity in the item descriptors for colonoscopy and has signalled a willingness to introduce new items. This would be a cost neutral addition to the MBS and allow more informative monitoring on the use of colonoscopy to be achieved. The Committee has requested an options paper from the Department on possible changes to the items for its consideration.

Priority review – Upper GI endoscopy with Colonoscopy – Preliminary findings

The Committee reviewed the service data for upper GI endoscopy co-claimed with colonoscopy and has noted the very significant variations in the rate of co-claiming between providers. The Committee has discussed whether the item descriptor could be amended or MBS explanatory notes provide clearer guidance on the circumstances in which providing bi-directional endoscopies on the same patient on the same day is appropriate.

Other reviews—Preliminary findings

The Committee has identified a number of item descriptors that require amending and will be included in the review report. These include:

- three interventional upper GI endoscopy items;
- two colonoscopy/ sigmoidoscopy items; and
- one capsule endoscopy item.

The Committee has also identified the need to review the role and use of capsule endoscopy in clinical practice, including the fee, which is potentially over funded

Ear, Nose and Throat Surgery Clinical Committee

In December 2015, the ENT Surgery Committee endorsed a report outlining the priority review topics of tonsillectomy, adenoidectomy and grommets. The Taskforce is expected to consider the report in March 2016 prior to conducting consultation.

The report identifies issues which have broader application across the MBS, including the implications of including patient indications in item descriptors.

The report also signals the need to address financial misuse of the MBS (e.g. co-claiming of additional MBS services which should be considered part of the original service and have financial implications for patients).

The Committee has recommended that the rest of the work programme be deferred pending guidance from the Review's Principles and Rules Committee on the design of item descriptors and inclusion of appropriateness criteria. This advice is essential for the review of procedural items.

Priority reviews—Tonsillectomy—Preliminary findings

Key recommendations from the Committee to the Taskforce included:

- That the fee differential between GPs and specialists be removed.
- That for tonsillectomy services:
 - the age restrictions be retained (under 12 year olds and over 12 year olds);
 - the service be clarified to include examination of the post nasal space, nasopharynx and larynx, and infiltration of local anaesthetic; and
 - restrictions be introduced to prevent co-claiming of tonsillectomy with similar MBS items for examination of the post nasal space, nasopharynx and larynx, and infiltration of local anaesthetic.
- That the Department of Human Services be encouraged to provide additional reports on individual provider activity to individual providers by item in way which allows practitioners to compare their individual practice to that of their peers.
- That further work to identify the reasons for geographical variation for these services is warranted.

Priority review—Adenoidectomy—Preliminary findings

- That the fee differential between GPs and specialists for be removed.
- That the item descriptors for adenoidectomy should be amended to clarify that the service includes examination of the post nasal space, nasopharynx and larynx, and infiltration of local anaesthetic. Where these or other items that are inherently part of the procedure, appropriate restrictions should be introduced to prevent co-claiming of the services with adenoidectomy.

Priority review—Grommets—Preliminary findings

- That no changes to the item descriptor for insertion of grommet (item 41632) are necessary.
- That further work looking at the reasons for geographical variation for these services is warranted in the future.

Obstetrics Clinical Committee

Preliminary findings

- That the GP 'G' item for ectopic pregnancy be removed and a single fee be set at the current specialist rate.
- That, consistent with the Australian Health Ministers' Advisory Council 2012 *Clinical practice guidelines: Antenatal care—Module 1* (with the addition of testing for Hepatitis C) the pathology tests that are routinely provided to all pregnant women in

the first trimester should be included in one item. This issue has been referred to the Pathology Clinical Committee for consideration.

- That item 16590 be amended to add a requirement that the provider has hospital admitting rights (but noting that there may be further amendments to include a requirement for a mental health screen).
- That the current item for mid-trimester delivery be amended item and a new item added.
- That the delivery items be combined when the patient has been transferred by a participating midwife.

Thoracic Medicine Clinical Committee

Work in progress—Lung function tests

At present, item 11503 is an umbrella item for a range of simple to complex laboratory-based respiratory function tests. Members have agreed that the service should reflect the fee for the service by describing clinically relevant complex respiratory function tests. The Committee is finalising advice to the Taskforce on amendments to the MBS items.

The Committee agreed that spirometry is largely performed by GPs under item 11506 to diagnose asthma, chronic obstructive pulmonary disorder and other causes of airflow limitation. However, ‘reversibility’ testing (pre- and post-bronchodilator spirometry) tends to be underused with many patients being prescribed therapy before the diagnosis is confirmed. The Committee holds the view that the cost of the service combined with the time needed to perform it appropriately present barriers to reversibility testing. An evidence review of spirometry is underway with the report to be considered at the March 2016 meeting.

Work in progress—Sleep studies

The Committee is currently considering options for revising the MBS descriptors for adult sleep study items.

Diagnostic Imaging Clinical Committee

The Committee has identified a number of obsolete items, and agreed to the formation of three Working Groups to address topics for priority review:

- bone mineral densitometry—dual-energy X-ray absorptiometry;
- duplex ultrasound for deep vein thrombosis and imaging (including computed tomography angiography) to exclude pulmonary embolism; and
- imaging of the knee.

The draft report from the Bone Densitometry Working Group is currently with members for clearance. It is expected that this report will be considered by the Committee in February 2016.

MBS Principles and Rules Committee

Preliminary findings

There are 34 current MBS services for which two items exist allocating lower and higher fees to general practitioners and specialists respectively (‘G&S’ items). The Committee recommends abolishing this differential arrangement on the principle that MBS benefits are paid for the provision of a surgical service by a medical practitioner should regardless of the

medical practitioner’s background qualification. The Committee notes that other safeguards exist to ensure quality service provision including hospital credentialing. A single fee for these services should be set at the higher specialist rate.

While the Committee arrived at this position through its own deliberations, this approach has been independently supported by the Obstetrics and the Ear, Nose and Throat Clinical Committees.

Clinical Committees—MBS items

Gastroenterology Clinical Committee

Gastro-oesophageal reflux disease

11800, 11801, 11810 (3 items)

Capsule endoscopy

11820, 11823 (2 items)

Diagnosis of abnormalities of the pelvic floor

11830 (1 item)

Gastric Hyperthermia

13500 and 13503 (2 items)

Oesphagoscopy and endoscopic procedures on the Oesophagus

30473. 30476. 30478. 30479. 30490, 30687 (6 items)

Dilatation of upper GI tract

30475, 41819, 41820, 41828, 41831, 41832 (6 items)

Gastrostomy

30481, 30482, 30483 (3 items)

Examinations and procedures on bile ducts/Pancreas

30484, 30485, 30491, 30492, 30493, 30494, 30495 (7 items)

Other procedures on the bowel

30487, 30488 (2 items)

Examination of the small bowel by balloon enteroscopy

30680, 30682, 30684, 30686 (4 items)

Endoscopic ultrasound with biopsy for staging of GI cancers

30688, 30690, 30692, 30694 (4 items)

Insertion of nasogastric tube

31456, 31458 (2 items)

Examination of the bowel – colonoscopy and sigmoidoscopy

32023, 32072 – 32095 (11 items)

Ear, Nose and Throat Clinical Committee

Diagnostic procedures

11300–11339 (16 items)

Therapeutic procedures to remove tumours of the upper aerodigestive tract

31400–31412 (5 items)

Therapeutic procedures: Surgical items ear, nose and throat

41500–41816, 41822, 41825, 41834-41886, 41907 and 41910 (144 items)

Note that items 41889 to 41898 and item 41905 (5 items) although located in the ENT section of the MBS, were assigned to the Thoracic Medicine Clinical Committee as that specialty is the main provider of those items. Similarly, items 41819 and 41820 and items 41828–41832 (5 items) although located in the ENT section, were assigned to the Gastroenterology Clinical Committee as that specialty is the main provider of those items.

Audiology

82300–82332 (9 items)

Obstetrics Clinical Committee

Therapeutic procedures: Obstetrics

16399–16636 (42 items)

Diagnostic imaging services: Obstetric ultrasound

55700–55775 (50 items)

Diagnostic imaging services: Radiographic examination in connection with pregnancy

58503–59504 (2 items)

Pathology services specifically related to pregnancy

66517, 66545, 66548, 66743, 66750, 66751, 69405, 69408, 69411, 69413, 69415, 73529, 73806, 73833 (14 items)

Therapeutic procedures: Assisted reproductive services

13200–13292 (14 items)

Thoracic Medicine Clinical Committee

Respiratory function test

11500 to 11512 (5 items)

Sleep studies

12203 to 12250 (7 items)

Therapeutic procedures—biopsy of lung cancers

30696 and 30710 (2 items)

Therapeutic procedures—bronchus or trachea

41889 to 41898 and 41905 (5 items)

Diagnostic Imaging Clinical Committee

MBS Category 5 – Diagnostic imaging services

Ultrasound (Group I1)

55005–55855 (196 items)

Computed tomography (Group I2)

56001–57361 (88 items)

Diagnostic radiology (Group I3)

57506–61110 (260 items)

Magnetic resonance imaging (Group I5)

63001–63523 (193 items)

Management of bulk-billed services (Group I6)

64990 and 64991 (2 items)

Bone densitometry—Diagnostic procedures (Group D1)

12306–12323 (7 items)

MEDICARE BENEFITS SCHEDULE REVIEW

**Summary of stakeholder forum and online
survey consultations**

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A message from the Review Taskforce Chair

Thank you to all who provided input to the MBS Review. Reading your responses gave me a renewed sense of purpose as to why this Review process is so important, for all of us who use our healthcare system but also for those who work in it. I read many stories of health professionals frustrated by the Medicare Benefits Schedule (MBS) rules that prevent them delivering best-quality clinical care, and concerning stories of patients exposed to unnecessary services and in some instances risk.

This report cannot do justice to the richness of feedback we received. More detailed collations of the input will be passed to the relevant Review Clinical Committee and will be incorporated into the discussions of these health professionals as they debate how best to update our MBS.

I welcome any additional input you may have via the official email address for this Review: MBSReviews@health.gov.au. Please also take the time to sign-up to the MBS newsletter to keep up-to-date with the Review and any future opportunities to give your valued input.

I thank you again for your input, and welcome your ongoing contribution to the MBS Review.

Professor Bruce Robinson

1. Introduction

The MBS Review Taskforce believes that public consultation, both with health professionals and consumers, is essential for a successful MBS Review. During the second half of 2015, the Taskforce conducted initial consultations with the community to help define the focus of the Review. These included in-person stakeholder forums, online consultations, and a formal submissions process. The Taskforce and Clinical Committees will seek further input as they develop and refine their recommendations.

This report synthesises the feedback received through the stakeholder forums and online consultations—a separate report will address the formal submissions received—and draws out common themes found. It is not intended to indicate the Taskforce's or the Department's position on any of these issues.

The report is divided into seven sections:

- Section 1 outlines the purpose of the MBS Review and the consultation process.
- Section 2 reports the number and composition of participants through each of the consultation channels.
- Sections 3 reports the attitudes of health professionals and consumers towards the Review and the nature of difficulties experienced when engaging with the MBS.
- Section 4 synthesises the feedback received on individual MBS services or types of services, with a particular focus on mental health.
- Section 5 draws together the input received on macro or cross-committee issues—that is, regulatory or policy areas affecting multiple Review Clinical Committees.
- Section 6 reports the feedback received on how the Review needs to be conducted in order to improve health outcomes.
- Section 7 outlines the next steps for the review and the plan for ongoing consultation.

1.1. The MBS Review

As part of the Australian Government's *Healthier Medicare* initiative, the Taskforce is undertaking a review of the entire MBS to ensure it reflects current best clinical practice and supports services that improve health outcomes. Currently, the MBS lists more than 5,700 services, many of which have never been subject to evidence-based assessment.

An important objective of the review will be to ensure that patients receive appropriate care for their circumstances by removing unsafe or outdated services from the MBS, and reducing the number of overused low-value tests and procedures. This will allow Government investment to be directed to the most effective, evidence-based services.

1.2. Overview of review process

The MBS Review is a clinician-led process which will be conducted over the next two years. Clinical Committees, made up of clinicians, other health professionals and consumer representatives, are responsible for evaluating the clinical evidence for a given practice area of the MBS.

In total, it is anticipated that there will be over 30 Clinical Committees driving the MBS Review. To date, five of these Committees have been launched: obstetrics; ear, nose and throat; gastroenterology; thoracic medicine; and diagnostic imaging. They are expected to deliver their first round of draft recommendations for consultation in early 2016.

The work of the Clinical Committees is supported by the Principles and Rules Committee, which will advise on matters related to the legislation underpinning the MBS, as well as other non-clinical issues pertaining to the broader design and structure of the MBS.

The Committees and the Taskforce will be consulting on an ongoing basis as findings and recommendations are brought forward, and prior to the Taskforce finalising any recommendations to the Government. Relevant professional organisations, other peak bodies, clinicians and consumers are encouraged to continue their involvement in the review process through online consultation and formal submissions.

1.3. Overview of the consultation process

Purpose of the consultation

The purpose of the initial period of consultation was to guide the Taskforce in its work and identify areas for priority action. Specifically, the consultation aimed to provide the Taskforce and Clinical Committees with stakeholder input on four key questions:

- What are the views of stakeholders regarding the review?
- Which specific items should be brought to the Clinical Committees' attention?
- Which issues applying to the whole of the MBS should be addressed by the Taskforce?
- What factors should be taken into account when conducting the Review?

Method for the consultation

The consultation process allowed stakeholders to provide input through three main channels.

- The Consultation Hub

The Consultation Hub is the Department of Health's online survey tool, enabling multiple simultaneous consultations. The MBS survey was open for a period of six weeks between 27 September and 9 November 2015. Participation in the survey was promoted by the Department through its website and Twitter, as well as at the stakeholder forums.

The survey was designed to facilitate input from health professionals and consumers. To this end, the survey had two streams of questions. One set of questions was directed at a broad audience, including health professionals, while the other focused on the experiences of health service consumers. Respondents could answer questions from one or both of the survey streams.

Respondents answered a combination of quantitative and qualitative questions, although the emphasis in this consultation was on providing respondents with the opportunity to fully develop their thoughts through free text responses.

- Stakeholder forums

Five stakeholder forums were held in Canberra (8 July), Adelaide (24 July), Perth (25 July), Melbourne (27 October) and Sydney (3 November). The forums provided the opportunity for the Taskforce to explain the proposed reform process, and for stakeholders to contribute feedback on the direction of the Review.

The content of the forums evolved over time, with the July stakeholder forums focused on the overarching purpose of the review, and later stakeholder forums directed at seeking input on the MBS system and individual MBS items.

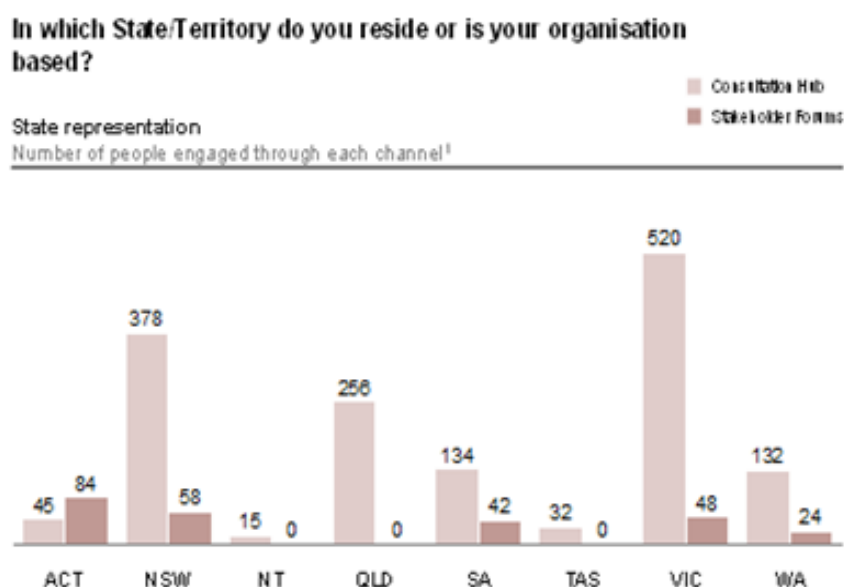
- Email and written submissions

Over 250 submissions were received from various organisations, peak bodies and medical colleges. These submissions continue to be analysed, and are not reflected in this document.

2. Level of response

Approximately 1,800 members of the community contributed feedback on the MBS Review via the Consultation Hub and stakeholder forums. They represented all states and territories, as well as a variety of clinical and consumer perspectives (see Exhibit 1).¹¹ Half of all responses received were from consumers or consumer organisations, while health professionals made up over 40 per cent of responses. Academics and carers were also represented, although in smaller numbers (see Exhibit 2). Other stakeholders, particularly at the stakeholder forums, included healthcare industry representatives.

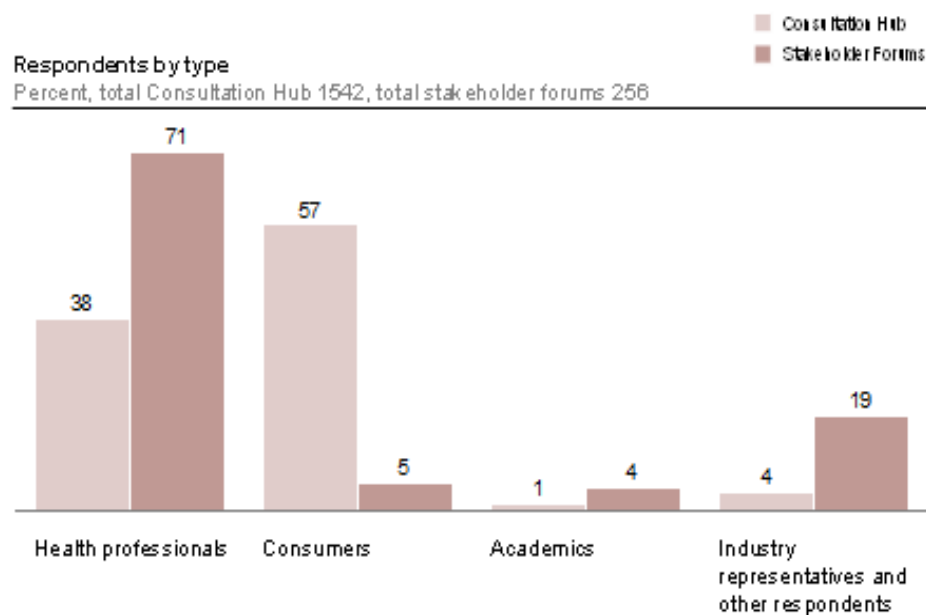
Exhibit 1: PROFILE OF RESPONDENTS BY STATE



¹ 30 non-responses to the question on Consultation Hub, excluded. State representation for the stakeholder forums was determined based on the location of the forum rather than state of residence of the attendees.

¹¹ The number of respondents by state was generally proportional to each state's population. There was a slight overrepresentation of Victoria and the Australian Capital Territory, and slight underrepresentation of New South Wales and Western Australia.

Exhibit 2: PROFILE OF RESPONDENTS BY TYPE



It should be noted that neither the Consultation Hub survey nor the stakeholder forums reflect a representative sample of the Australian medical community, or the Australian community more broadly. The high response rate to the Consultation Hub survey was due, in part, to a number of community and professional campaigns related to the limit on psychology attendances, and the inability of physiotherapists to refer to specialists.

The next sections detail the responses to the four key questions on which the stakeholder consultation was based.

3. What are stakeholder attitudes towards the Review?

3.1. Health professionals and consumers recognise the need for a review of the MBS

Amongst health professional respondents, there was strong consensus that the MBS Review is necessary. In the Consultation Hub survey, health professionals were asked: 'Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?' Of 585 health professionals who answered the survey, 93 percent answered 'yes' to this question.¹²

The experiences of consumers also reinforced the need for the MBS Review. Consumers emphasised that the issue was not the overall design and approach of the MBS, but its current performance in very specific areas.

Consumers generally valued the MBS as a system which supports access to high-quality healthcare. For example, one consumer response read: 'I have chronic pain and live on a disability support pension. Thanks to Medicare I am able to access appropriate support services, particularly a pain specialist. With his help I have been about to reduce medication

¹² 1 percent responded 'no' and 6 percent were unsure. There were 2 non-responses (less than 1 percent).

to 10 per cent of what it was 3 years ago. I'm also able to participate in more community activities.'

However, consumers advocated for a review of the MBS in several key areas. This included where MBS funding encourages the provision of unnecessary or unsafe medical services, or where consumers found it difficult to access services because of cost. To illustrate the latter, one consumer reported that 'The MBS has allowed so many people I know access to care and services that they would not have been able to if it was not in place, mostly psychological services. Having said that, the number of sessions and percentage of cover is not enough.' A common theme was that the MBS works well for basic general practitioner (GP) care where patients are bulk billed, but that specialist services, including diagnostic imaging services, are often unaffordable.

Overall, consumers and health professionals want the MBS to do a better job of achieving the healthcare outcomes it was set up to provide: accessible, affordable and safe healthcare based on the needs of individual consumers.

3.2. Specific items and groups of items require review

Feedback on where the MBS requires review can be divided into two main areas: problems with specific MBS items or groups of items, and issues applying to the whole of the MBS, such as concerns regarding MBS rules or the MBS funding structure. Below is a brief summary of these two areas, with further detail in Sections 4 and 5.

Many health professionals provided in-depth feedback on individual MBS items or groups of items. Broadly, feedback highlighted four types of issues associated with current MBS items: overuse of low-value services, underuse of high-value services, obsolescence, and misuse. Approximately 300 health professionals provided specific examples of low-value and high-value usage through the Consultation Hub, as well as examples of obsolete items or misuse. Additionally, the stakeholder forums in Sydney and Melbourne identified a number of examples of low-value service usage, high-value services which may be underused, obsolete services, and items being misused. An overview of each type of issue is provided below, with more comprehensive discussion in Section 4 of this report:

Overuse of low-value services

These are services that are used in circumstances where they offer little, if any, clinical benefit to consumers, and may be unsafe. Examples include where a test is not clinically indicated (e.g. lower back imaging on first presentation of back pain with no 'red flags'); tests being repeated for administrative rather than clinical reasons (e.g. repeat pathology tests because the new provider does not have access to previous results); or where services pose an unacceptable risk to patient safety relative to the potential benefit that can be gained.

Underuse of high-value services

These are services for which the potential benefit to consumers exceeds the risk and costs, but which are currently not being provided to all appropriate patients. This may occur where MBS fee levels misdirect service provision (e.g. the reported underuse of intrauterine devices), or where the quantity of services provided does not align with clinical need (e.g. service limits of 10 psychology sessions per year for patients with ongoing serious mental health conditions).

Obsolete services

These are services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures (e.g. injection of hormones for the treatment of habitual miscarriage).

Misuse of MBS services

This refers to instances where providers use the MBS for a purpose other than which it was intended. This includes a spectrum of behaviours ranging from failing to adhere to particular item descriptors or rules, through to deliberate fraud. Suggestions of possible misuse have been referred to the compliance area of the Department of Health for further investigation.

3.3. Whole-of-MBS issues

There were three main types of issues applying to the whole of the MBS raised by respondents. First, health professionals and consumers often reported that inappropriate MBS rules currently limit access to healthcare. Second, health professionals and consumers alike reported that there was currently inadequate information available on the MBS and the services it subsidises. Finally, stakeholders also had more wide-reaching concerns about the structure and administration of the MBS, and the types of care it currently incentivises. Each of these issues is described below, with more detailed discussion in Section 5 of this report.

MBS rules and regulations

Difficulties with MBS rules and regulations were a consistent theme in feedback received at the stakeholder forums and through the Consultation Hub. 67 per cent of health professionals who responded to the Consultation Hub survey reported that MBS rules and regulations need to be reviewed—either for the whole MBS, for individual items, or both. Furthermore over 60 per cent of consumers responding to the survey reported they have encountered difficulties with Medicare rules.¹³

While a diverse range of MBS rules were raised by stakeholders, there were three common areas relating to MBS rules and regulations which were raised by health professionals and consumers through each channel of the consultation.

Referrals

Both health professionals and consumers raised as requiring review the issues of referrals and/or the role of GPs as gatekeepers to specialists or to diagnostic procedures. At the stakeholder forums in Melbourne and Sydney¹⁴ 32 per cent of participants ranked this issue as amongst the five most important for the Taskforce to review.¹⁵ It was the second most

¹³ Includes consumers, consumer representatives and carers.

¹⁴ Attendees at the Stakeholder forums in Sydney and Melbourne were specifically asked to rate their most important rules or regulation issue. Attendees at other forums were not asked this question.

¹⁵ Participants were asked: 'which cross-cutting issues should be prioritised? Please discuss these cross-cutting issues with your group and rank the top five which seem most important to address. Feel free to add additional suggestions of your own on the next page.'

commonly raised issue affecting the whole of the MBS by health professionals and consumers responding through the Consultation Hub.

Responding through the Consultation Hub, consumers were often frustrated by the process for repeat referrals. For example, one consumer reported: 'When two of our kids needed to see a dermatologist for severe acne, we had to go to the GP a few times for referrals and then updated referrals. What a waste of time and money!' Many allied health professionals also wanted the ability to directly request pathology tests or imaging for their patients, without needing to go through a GP.

MBS fees and prices

Participants at both the Melbourne and Sydney stakeholder forums ranked MBS fees and prices as the most important issue applying across the MBS. Over 60 percent of respondents ranked this issue amongst the top five issues applying to the whole MBS.

Additionally, through the Consultation Hub 254 consumers raised issues with MBS gaps or excessive fees, representing almost 30 per cent of all consumer respondents. Many reported being in significant financial distress as a result of their medical costs.

Although MBS fees and prices are important factors in achieving health outcomes, they are not the primary focus of the present Review. They will however be considered by Clinical Committees, where there is evidence that current pricing is distorting service provision, or when a Committee is framing recommendations for significant changes to MBs items including bundling.

Service limits

Service limits were the issue most often raised by consumers, particularly in relation to mental health services. Over 200 consumers raised this issue, representing 50 per cent of consumers who cited issues with Medicare rules.

For example, one consumer writing on the Consultation Hub reported: 'I suffer from a range of mental health issues linked to anxiety. After some life events that were very distressing I badly needed to see a psychologist but since I had already had a mental health plan and accessed a psychologist at the start of the year, I was not entitled to any more Medicare covered appointments until the next year (2 months away). I did not have the financial means to cover the cost of the appointments myself and as such went without help and my symptoms and conditions became much worse.' Allied health professionals, particularly psychologists, also raised the issue of service limits through the Consultation Hub.

The range of eligible providers

This issue was most commonly raised by health professionals, particularly those responding to the online survey. It was ranked in the top five cross-committee issues by 40 percent of attendees at the Melbourne and Sydney stakeholder forums.

It was also the issue most commonly raised by health professionals through the Consultation Hub, representing a third of responses on MBS rules affecting the whole of the MBS.

In responses to the online survey many health professionals, particularly those working in allied health or nursing fields, argued that rules placed undue restrictions on health professional eligibility to provide MBS services. For example, one respondent observed:

‘Practice nurses are effective at providing self-management support, and extending Medicare benefits to reimburse practice-nurse time would provide an opportunity to deliver self-management support without additional burdens on GPs.’

Communication—using the MBS

Improved flow of information between providers, consumers and the Government was one of the major shifts that participants in the July stakeholder forums suggested was necessary. Participants in those forums suggested the MBS needs to change from an opaque system with poor data linkages, to a transparent system that is evidence based and data driven. This sentiment was also reflected at the Sydney and Melbourne forums —45 per cent of participants ranked transparency surrounding usage, variation and fees in the top five issues applying to the whole MBS.

The Consultation Hub survey asked health professionals and consumers what kind of information consumers required to participate in their healthcare decisions. Both groups reported that consumers needed clear information on their condition, as well as the risks and benefits of any treatment. Consumers particularly emphasised the importance of cost information. Increased information on costs, MBS rebates and entitlements was the most commonly requested type of information, and was cited by over a third of consumers.

Broader shifts in the MBS and its administration

Many health professionals raised issues with the MBS funding structure and the type of clinical practice it currently incentivises. Participants in the July stakeholder forums raised this as one of the overarching changes in thinking required for a successful MBS Review. They suggested that the MBS needs to shift from focusing on sickness to focusing on wellness, and from rewarding activities and tasks to rewarding outcomes.

This concern was also reflected at the Sydney and Melbourne stakeholder forums. Complementing the MBS with outcomes-based reimbursement was ranked third in the most important issues for the Review to address, and was cited in the top five of nearly half of participants. Contributors to the Consultation Hub also raised concerns about the MBS funding structure, arguing ‘the entire notion of a retrospective payment as a fee-for-service does not encourage wellness in patients.’

4. Which specific items should be brought to the Clinical Committees’ attention?

Stakeholders provided feedback on individual MBS items or groups of items through multiple channels.

Participants at the Melbourne and Sydney stakeholder forums were specifically asked to identify items requiring review. Through the Consultation Hub, health professionals were asked, ‘Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part the Review as a priority?’ Health professionals were also asked to identify high-value services in their responses to the question, ‘Which services funded through the MBS represent high-value patient care and appear to be underutilised?’

Respondents in the MBS users stream were asked ‘Have you or someone you know ever had a consultation, medical procedure or test you thought was unnecessary? If yes, what was the medical procedure or test, or what was the consultation for, and why did you think it was unnecessary?’

It should be remembered that many of the comments on perceived low value, underuse, obsolescence or misuse were made from the personal perspective of the respondent—whether consumer or health professional—and relate to their particular circumstances. Such views are clearly not evidence-based assessments of the actual clinical utility of the services. These views are useful to the Review as they draw attention to the experiences of patients and the active role that some patients take in their healthcare. It should also be remembered that the following results reflect the opinions of health professionals and consumers who participated in the consultation process. This does not amount to conclusive evidence that such services are in fact low value, nor is it a representative sample.

These comments will be summarised and provided to the relevant Clinical Committee for their consideration.

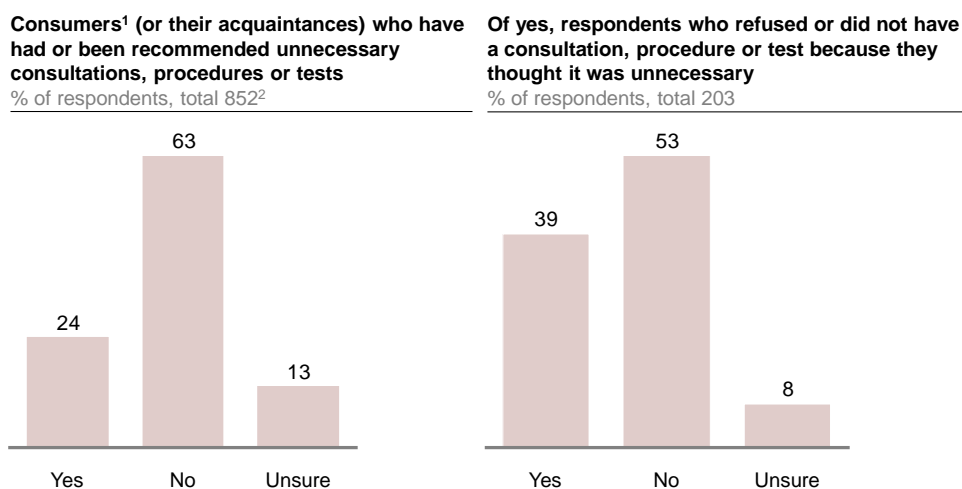
4.1. Overuse of low-value services

Stakeholders reported many instances where they believed MBS services did not deliver value for the healthcare system because they were provided to patients who were unlikely to benefit, or with inappropriate frequency. That is, reported ‘low-value services’ were very rarely inappropriate for all patient groups; more commonly the complaint concerned the provision of services in circumstances where for *that particular type of patient* the benefits did not outweigh the risk or costs.

Both health professionals and consumers raised Medicare funding of low-value services. Through the Consultation Hub, approximately 300 health professionals provided specific examples of items they believe are being used for low-value purposes, while at the stakeholder forums participants provided 32 examples of the overuse of low-value services.

Exhibit 3: CONSUMER REPORTS OF UNNECESSARY MEDICAL PROCEDURES

Have you or someone you know ever had or been recommended a consultation, medical procedure or test you thought was unnecessary?



¹ Includes consumers, consumer representatives and carers
² 24 non-responses excluded
 Source: Consultation Hub

One quarter of consumers also reported that they, or an acquaintance, had received or been recommended a consultation, medical procedure or test that they believed to be unnecessary (see Exhibit 3). Of these 203 consumers, most accepted their health providers' advice and went ahead with the procedure.

The feedback received across each of these three channels was analysed based on the type of low-value item cited (see Exhibit 4). While the range of items identified indicates there is no one area on which to focus efforts to reduce inappropriate usage, three areas were commonly cited across all stakeholder groups. These areas—administrative GP consultations, unnecessary diagnostic imaging and pathology testing, and unnecessary surgery—will be addressed in turn.

Exhibit 4: REPORTED OVERUSED LOW-VALUE SERVICES

Which services funded through the MBS represent low value patient care (including for safety or clinical efficacy concerns) and should be looked at as part of the Review as a priority?

Ten most commonly cited types of low value items

Number of times cited, total 346 health professional responses¹

Administrative GP consults	74
Inappropriate range of allied health providers	49
Inappropriate diagnostic imaging	45
Unnecessary or ineffective surgery	45
Inefficient provision of psychological services ²	34
Orthopaedics, esp. arthroscopy	25
Unnecessary pathology tests	11
Unnecessary O&G intervention	6
Unnecessary gastroenterology procedures	5
Unnecessary ENT procedures	5

¹ Health professionals were able to identify multiple low value items; 457 areas mentioned across the 346 health professionals

² Not including GP mental health care consultations

O&G - Obstetrics and Gynaecology

ENT – Ear Nose and Throat

GP consultations that appeared to be driven by administrative requirements

Comments about GP consultations initiated by consumers seeking GP advice and treatment were generally positive. However, GP consultations that were considered to be administrative rather than diagnostic or treatment focused were commonly cited as low value by health professionals and consumers. This type of GP visit included attendances for ongoing referrals to specialists or to obtain a medical certificate.

Approximately 87 per cent of Australians attended a GP in 2014–15 and the number of reported instances of types of low-value attendances should be read in this context. Of the 346 health professionals who answered the qualitative question on low-value items, 74 nominated GP attendances, including mental healthcare plans. This largely reflected the substantial number of contributions received from psychologists, physiotherapists and other allied health providers, putting the view that patients should have MBS-funded access to their services, or services referred by them, without needing a GP referral.

198 consumers reported receiving an unnecessary medical service and described their experience. Of these, 85 cited instances where they believed GP attendances were unnecessary, such as for repeat prescriptions or test results. For example, one consumer reported that GP consultations were unnecessary ‘where you are getting a blood test result,

especially when there is no medical concerns with the blood test. Why can't these be given over the phone or email or text?'

Over half of the instances of reportedly unnecessary GP attendances related to mental healthcare, particularly relating to the review of a mental healthcare plan so that the patient could receive an additional four sessions with a psychologist. This reflects the large proportion of consumers of mental health services who responded to the survey.

Chronic disease management items were also frequently cited as low-value services. One health professional reported through the Consultation Hub that 'the Chronic Disease Management (CDM) Plan is often ineffective and in some cases is being used in an inappropriate manner. Referrals under a Team Care Arrangement are often being made purely as a revenue generator by the referring GP/practice nurse. The patient is rarely informed of the MBS fee the referrer will receive by arranging the plan and patients report they are pressured into it. The practice nurse (which is government rebated) usually performs the bulk of the work.' However, another participant at the Sydney stakeholder forum warned against abandoning the CDM programme: 'Yes, [there are] problems with these items but *please* don't throw the baby out with bathwater. These items are critical to support team based multi-disciplinary care. Re-engineer the items – don't disregard them.'

Unnecessary diagnostic imaging and pathology tests

Unnecessary diagnostic imaging and pathology tests were identified by both health professionals and consumers as areas requiring review. For consumers, unnecessary diagnostic imaging and pathology tests were the second most commonly cited area for unnecessary MBS services. Nearly 20 per cent of consumer respondents to this question reported unnecessary diagnostic imaging and 15 per cent reported unnecessary pathology testing. For health professionals, unnecessary diagnostic imaging was the third most commonly cited type of low-value service.

Repeat testing was also a common concern. One consumer reported that they received 'multiple blood tests ... ordered by different doctors as the test laboratory often do not follow requests and provide copies to doctors as requested.' For some consumers over testing led not only inconvenience, but also exposed patients to unnecessary risk. One parent reported 'my son has had an X-ray for a chest infection four times. He has also had four hip X-rays. He is only 20 months old.' A participant at the Sydney stakeholder forum similarly raised concerns about the risks of unnecessary diagnostic imaging, reporting that 'a CT scan is often requested when a projection X-ray would suffice. This takes longer to perform, longer to report, uses more expensive equipment and uses ~10-100X as much radiation.'

Unnecessary surgical intervention

Less commonly mentioned was unnecessary surgical intervention. However, when this issue did arise, the implications in terms of unnecessary patient risk were often more serious. Commonly cited examples included inductions of labour and caesareans for no medical reason, knee arthroscopy for patients with osteoarthritis, and circumcision in healthy male infants. A number of respondents to the survey indicated that surgery should not be considered unless conservative treatments had been undertaken—for example, physiotherapy for incontinence or prolapse, or physiotherapy for back pain rather than spinal surgery.

Respondents pointed to a number of instances where they believed the risk of surgical intervention was not justified by the likely health benefit. One consumer reported that if sympathectomy for palmar hyperhidrosis (excessively sweaty hands) ‘was not available absolutely free of charge funded by Medicare, I would not have had the procedure, and I would not be on a disability pension. It was an absolutely unnecessary procedure for a condition that was not severe and did not adversely affect my life.’

Occasionally, surgical intervention was reported to have caused serious medical complications. A number of respondents explained that they had a bladder sling inserted to address stress urinary incontinence, but that when this caused intense pain and damage to their internal organs there was no surgeon in Australia able to remove the mesh. The Department of Health has referred this issue to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists for advice.

4.2. Underused high-value services

Underused high-value services mirror some of the problems associated with overused low-value services; health outcomes are compromised because consumers do not receive the most appropriate treatment for their circumstances. Health professionals responding through the Consultation Hub were asked to identify high-value services that appear to be underutilized—approximately 300 health professionals did so. Additionally, participants in the stakeholder forums identified 14 specific items or types of items which are potentially underused.

Many respondents suggested that longer consultations that allow a thorough taking of the patient’s medical history, diagnosis and counselling (rather than relying on tests and referrals to specialists) were underused, and that the underuse of these items was due to low MBS fees. One respondent through the Consultation Hub reported that ‘longer [GP] attendance items (level C and D) will be underused so long as they remunerate less per hour than lesser items.’ Others suggested that longer GP consultations would allow GPs to address diet, exercise and other preventative measures.

However overall feedback through these channels primarily centered around two types of underused items—allied health services and mental health services—again reflecting the over representation of respondents with an interest in these issues.

Allied health services, nurse practitioners and midwives

Underuse of allied health, nurse practitioner and midwifery services was the most commonly cited issue by health professionals.¹⁶ Approximately one third of health professionals responding to the Consultation Hub question on underused items identified these examples, most commonly in relation to physiotherapy or nursing services.

Physiotherapists often suggested that their services were underused in comparison to surgical intervention or medication. One respondent through the Consultation Hub reported that ‘targeted physiotherapy for lower back pain ... has been shown to be effective and this is an area where many patients are undergoing surgery that offers no significant benefit over physiotherapy (but comes at a huge cost). More funding for specific treatment areas

¹⁶ It should be noted that a large proportion of health professional respondents were allied health providers or nurse practitioners.

like this would reduce other costs such as surgery and pharmaceuticals, which are more expensive overall.'

Nurse practitioners and practice nurses reported that their expertise was being underutilised resulting in unnecessarily greater workloads for GPs. One respondent suggested the Taskforce review 'the need for a GP to see the patient when the service can be provided by a nurse, for example cervical screening and immunisation performed by nurses with graduate qualifications in these areas.' Other examples included midwifery services for low risk women, and MBS funding for perioperative nurse surgical assistants. Some respondents cited areas where they felt that MBS funding should be introduced, particularly where this would support preventative healthcare. Dental services, for example, were nominated by a number of respondents.

Mental health services

The second commonly reported underutilised service was mental health treatment, particularly access to psychologists for people with severe and ongoing conditions. In this context the most commonly raised issue was the current service limit of ten psychology sessions per calendar year. This allocation was repeatedly criticised, by both consumers and psychologists, as an insufficient amount of time to adequately address most mental health concerns, particularly for those who have significant complex needs and require ongoing intervention.

Both consumers and psychologists noted that they believe the effectiveness of psychological care is impacted by service limits. Some patients detailed how they often attempted to 'save' sessions and spread them out over a number of months, thereby limiting their access to care at crucial times, or reducing the efficacy of treatment due to long breaks between sessions. Furthermore, several practitioners stated that there was a risk of patients becoming disengaged or stagnant in their recovery progress, or experiencing worsening symptoms, as a result of being unable to afford ongoing care after their ten sessions had been exhausted.

The role of GPs as 'gatekeepers' to psychological services and the requirement that GPs initiate a Mental Healthcare Plan and review a patient's progress after six sessions with a psychologist was commonly considered to be inconvenient and unnecessary and only acted as an extra barrier to accessing support.

4.3. Obsolete services

A small number of obsolete services were identified through the Consultation Hub and at the stakeholder forums. At the Melbourne and Sydney stakeholder forums, participants identified 19 obsolete items. Examples included diagnostic imaging items such as Graham's test, and laryngoscopy. One participant noted that pelvimetry, an outdated method of determining whether a person requires a caesarian section by measuring their pelvis, still attracts a MBS rebate.

In the online survey, some respondents indicated that certain services or procedures were no longer appropriate to use for particular conditions. For example it was suggested that facet joint injections were no longer appropriate for chronic neck or back pain. Respondents identifying potentially obsolete services generally did not provide detailed substantiation of these claims. These services will be raised with relevant Clinical Committees for consideration. As with other Review recommendations, potentially obsolete services will be released for public consultation prior to the Taskforce recommending any changes to the MBS.

4.4. Misuse

Respondents in both channels identified a small number of items that are allegedly being misused by some providers. At the stakeholder forums, just three items were identified as currently being misused. Instances of misuse occurred on a spectrum of seriousness, ranging from examples of the MBS incentivising less appropriate care, through the systematic provision of clinically-unnecessary services, to fraudulent claiming practices.

Through the Consultation Hub, suggested misuse of items included exceeding the number of clinically necessary services—e.g. ‘The [GP CDM Plan] numbers 721, 723 are massively abused. They are good earners for some GPs who just want to do these annually’—through to MBS funding of services without sufficient clinical evidence. One respondent reported, “‘Group psychological therapy’ items are being flagrantly abused by many psychologists to fund everything from yoga workshops to public speaking workshops.’

Another respondent argued that sleep studies are ‘being directly sold to the public: they are being served through pharmacies and shops, customers are told to go get a signature from their GP, the sleep study report is often automated (or not released at all), and their common goal is to sell CPAP [Continuous Positive Airway Pressure] machines.’

It is important to note that these are unsubstantiated claims that have not yet been investigated. The Taskforce takes these alleged instances of misuse of public funding very seriously and all responses regarding the possible misuse of MBS items have been referred to the Department’s compliance area for further investigation. However, it should be noted that cases of misuse are rare and that most providers bill fairly.

4.5. Root causes underlying these issues

Although the items highlighted by respondents were drawn from multiple clinical areas, there were a number of common factors that underpinned many of the issues identified. Of these, the most commonly raised were the level of MBS fees, rules around eligible providers and their scope of practice, and concerns in relation to legal liability.

First, some respondents identified the level of MBS fees as disincentives for the use of some items. Some respondents viewed the current GP item structure as encouraging shorter GP attendances, and not providing appropriate remuneration for high-value care by encouraging ‘six minute medicine that allows some GPs to cream the system by seeing 10 patients an hour and earning \$380, while good GPs see four patients an hour and can only bill \$152 per hour.’

Second, many comments identified issues with the design of the MBS system itself, such as the need for a referral from a GP to see specialist, or to access some MBS-funded allied health services. Many stakeholders argued that these gatekeeping functions, which are intended to control unnecessary service provision, may themselves be an inefficient use of resources. These issues are discussed further in Section 5.

Third, a small number of health professionals suggested that perceived exposure to legal liability caused some providers to order more tests and investigations. to rule out even very unlikely diagnoses at the expense of the MBS system, patient time and money, and occasionally, safety.

5. Issues applying to the whole of the MBS

While the clinical evidence will be evaluated by the appropriate Clinical Committees, some areas of policy will affect the work of multiple committees, such as the referral system and the structure of MBS items (see Exhibits 5, 6, and 7). These issues are fundamental to a successful MBS Review and to improving health outcomes.

The Taskforce has established the Principles and Rules Committee to help develop responses to whole-of-MBS issues, and work collaboratively with the Clinical Committees to ensure these are clinically appropriate across different practice environments.

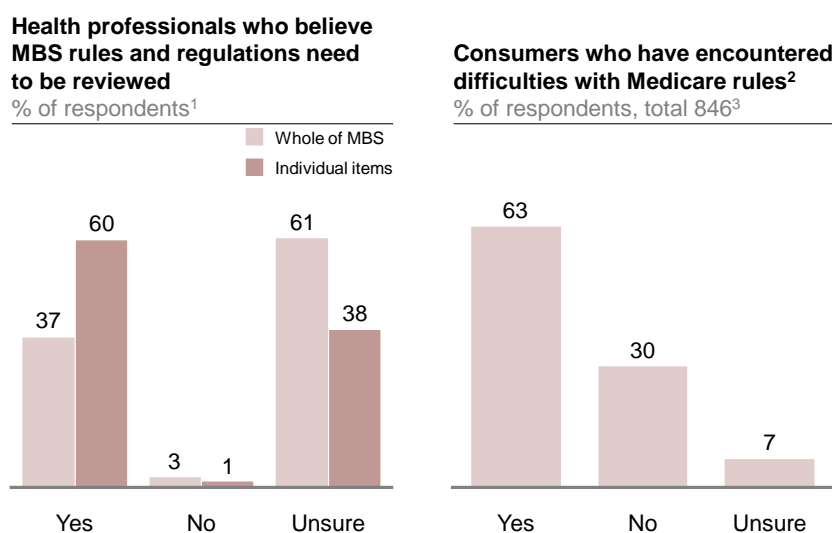
The Principle and Rules committee will develop an initial list of issues applying to the whole of the MBS to prioritise for review, based on input from the stakeholder forums, the Consultation Hub, consultation with community and professional organisations, and their own professional experience. The Taskforce and Clinical Committees are also able to refer issues to the Principles and Rules Committee.

This section of the report addresses three types of issues applying to the whole of the MBS. It first reports commonly raised MBS rules, with a focus on gatekeeping and referrals, MBS fees, services limits, and the range of eligible providers. Secondly, it discusses concerns surrounding information shared between health professionals, consumers, and the Government. Finally, it notes concerns raised around the MBS funding system and fee-for-service medicine.

5.1. MBS rules

Exhibit 5: MBS RULES AND REGULATIONS REQUIRING REVIEW

Are there rules or regulations which apply to the whole of the MBS or individual items which should be reviewed or amended?



¹ Total 558 rules for whole MBS, 552 rules for individual items; 27 and 33 non-responses excluded respectively

² Question adds: "For example had a Medicare benefit denied, difficulties with referral arrangements, or limits on the number of times you can access certain Medicare services in a year."

³ 30 non-responses excluded

Source: Consultation Hub

Health professionals and consumers reported that current MBS rules can at times impede the delivery of patient care. In the online survey, health professionals were asked two questions in relation to MBS rules: 'Are there rules or regulations which apply to the whole

of the MBS which should be reviewed or amended?’ and ‘Are there rules which apply to individual MBS items which should be reviewed or amended?’

In response to the first question, over one third of health professions answered ‘yes’ and in response to the second, 60 percent of health professionals answered ‘yes.’ Overall, 67 per cent of health professionals believe MBS rules and regulations need to be reviewed—either for the whole MBS, individual items or both. The high ‘unsure’ response rate to this question may itself indicate the uncertainty surrounding MBS rules.

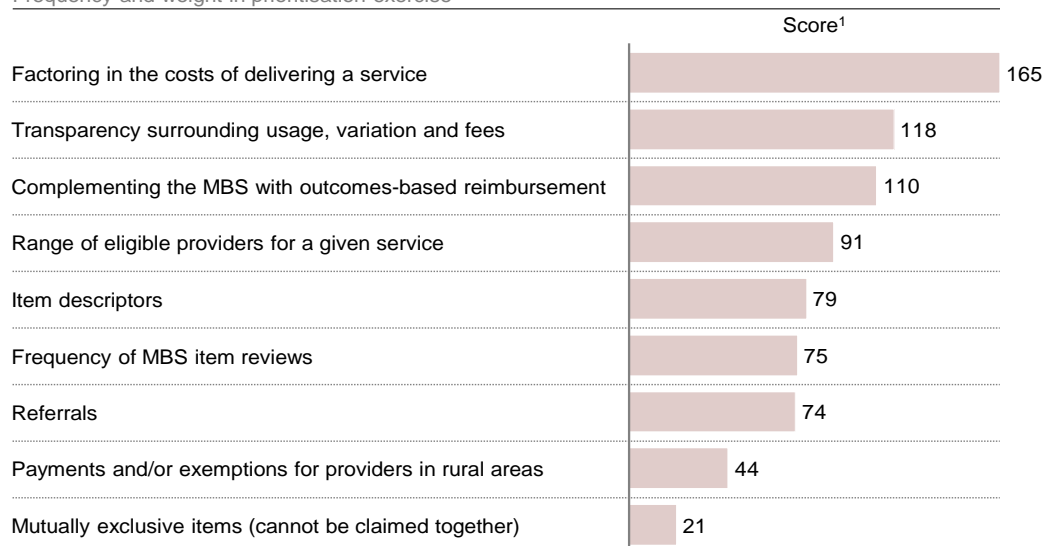
Consumers similarly reported difficulties with MBS rules. Over 60 per cent of consumers¹⁷ responding through the Consultation Hub reported encountering difficulties with Medicare rules, mostly relating to the provision of mental health. Of the 553 consumer responses identifying rules or areas where they had faced difficulties, 400 related to mental health.

Exhibit 6: STAKEHOLDER FORUM PRIORITISATION OF ISSUE AFFECTING THE WHOLE OF THE MBS

Which issues applying to the whole MBS should be prioritised for review?

Prioritisation of issues at stakeholder forums

Frequency and weight in prioritisation exercise



¹ Based on accumulated points whereby a prioritisation of '1' is worth 5 points, '2' is worth 4 points etc.
Source: Melbourne and Sydney Stakeholder Forums

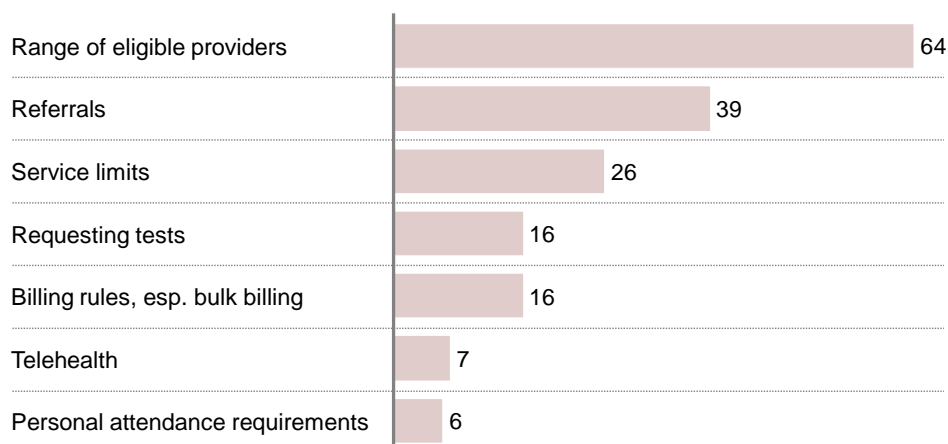
⁷ Includes consumers, consumer representatives and carers

Exhibit 7: ISSUES RAISED BY HEALTH PROFESSIONALS THROUGH THE CONSULTATION HUB

Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended?

Issues prioritised by health professionals in online feedback

Number of citations, total 214 health professional responses¹



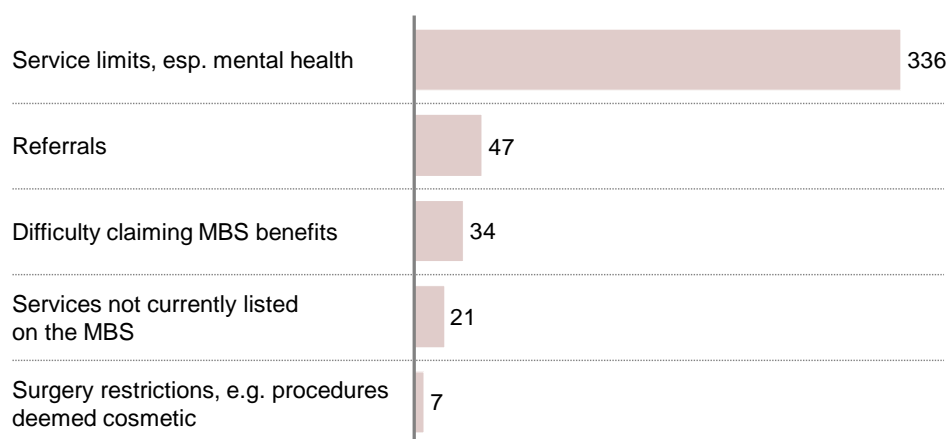
¹ Health professionals were able to nominate more than one rule or regulation, total 322 citations
Source: Consultation Hub

Exhibit 8: ISSUES RAISED BY CONSUMERS THROUGH THE CONSULTATION HUB

Have you encountered difficulties with Medicare 'rules'? If yes, please describe what happened

Cross-committee issues prioritised by consumers in online feedback

Number of citations, total 553 consumer responses¹



¹ Consumers could cite multiple areas, total 1332 citations
Source: Consultation Hub

Different types of stakeholders were asked for their input on issues affecting the whole MBS in three different settings. At the Sydney and Melbourne stakeholder forums, participants were asked to rank the top five issues affecting the MBS as a whole that the Taskforce should consider, based on a list prepared by the facilitator (see Exhibit 6). The

Consultation Hub asked health professionals to identify rules affecting the whole of the MBS that require review (see Exhibit 7), while consumers were asked to describe instances where they had encountered difficulties with Medicare rules (see Exhibit 8).

The results of the three surveys, displayed above, reveal that respondents in each context cited different rules as problematic, to varying degrees. However, several areas of concern were cited across stakeholder groups, or in significant numbers by a particular group. These areas—referrals, MBS fees and prices, service limits, and the range of eligible providers—will be addressed in turn.

Design of gatekeeper and referral arrangements

The design of gatekeeper and referral arrangements was the only issue common to all three groups. Responses focused on two issues: where the gatekeeping function of referrals was seen as unnecessary, and where requirements for repeat referrals wasted time and resources.

In relation to the first concern, many health professional respondents argued that referrals through GPs were unnecessary, particularly when accessing allied health services. It should be noted that the prevalence of this issue may reflect the skew towards allied health providers in the health professional respondent group.

This issue was also occasionally raised by consumers. For example, one consumer recounted her experience of needing a GP referral for knee surgery: ‘I requested the physio to write a letter to the doctor (which he did) and was quite angry when the doctor read the letter, wrote a referral saying, “thank you for seeing Jane Citizen with my DOB and please refer to physio notes.” It was totally unnecessary, a waste of my money and to make it worse I had to ask for all information to be forwarded to the physio *again* after an appointment with the doctor.’¹⁸

Consumers also argued that requiring a GP referral to access mental health services could act as a barrier to treatment. One respondent suggested that ‘having to access a GP for a referral is a barrier for some people and can hold up the process of individuals accessing psychological care.’ The effect of referral requirements such as these was that some consumers faced circular referrals, for example, where they attended an allied health provider only to be told to see their GP in order to access MBS rebates.

Additionally, a number of respondents, both health professionals and consumers, reported that the three-month limitation on specialist-to-specialist referrals was inconvenient and unnecessary. One specialist, for example, reported that ‘many GPs do not follow the advice I write in my letters to refer patients to other specialists, so I find it easier to refer them myself. It is a nuisance when I am asked to supply another referral because it has run out before their scheduled appointment.’

Consumers mirrored this frustration. One consumer was concerned that their ‘specialist referral only lasted 3 months and I had to keep seeing the person I was referred to for just over 3 months. This meant I had to see the original specialist (or my GP) for a new referral in order to continue treatment for just another 2 weeks. Overall very inefficient, waste of my

¹⁸ Name changed to protect privacy

time as well as of MBS funding for Medicare and would have been avoided if my original referral could have lasted longer.'

MBS fees and rebates

Health professionals and consumers frequently raised issues with MBS rebates. The issues raised by health professionals and consumers differed significantly. While health professionals tended to be concerned about MBS fees relative to other services or providers, consumers were generally concerned about the financial pressure caused by high fees and gaps.

Many health professionals suggested that the MBS lists inadequate fees for some items or that fee levels are incorrect relative to other services or providers. Other concerns related to where respondents believed the MBS fee had fallen out of kilter with the cost or complexity of providing the service.

Other health professionals raised concerns about the relative pricing between different types of providers. For example, many psychologists provided input on the two-tiered fee schedule for 'clinical' as opposed to 'registered' psychologists. It was suggested by some that overall patient outcomes do not greatly differ between the two classifications, while others noted the tiered fees reflected the differences in education and training.

For consumers, issues with cost often led to financial hardship or difficulties accessing healthcare. Some patients reported that high costs had meant that they received less care than they needed, or that they were unable to afford further care. Again, this was frequently reported by people seeking mental healthcare.

Issues with affordability were commonly cited in relation to specialist services. While many consumers reported that the MBS adequately supported GP visits, specialist care was often considered to be unaffordable. One consumer reported that the 'MBS works well if providers don't charge excessive fees above this. I had wrist surgery, and was out of pocket nearly \$1,000 just for my specialist.'

Many consumers appeared to have not been adequately informed about the out-of-pocket costs they would likely face. This will be discussed in greater depth below in relation to the types of information that consumers need in order to be more actively engaged in their healthcare.

While the Taskforce notes these concerns, MBS fees are not the immediate focus of the review. Clinical committees will, however, consider revising fees where there is evidence that current pricing is distorting the provision of healthcare.

Service limits

Service limits are applied to some MBS items to restrict the number of MBS-funded service within a particular period of time. These include the five session limit per calendar year for allied health services under chronic disease management plans, and the 10 session limit for psychology consultations.

Service limits were the most frequently raised MBS rule by consumers, with over 300 consumers referring to the difficulties they faced once their annual allocation of appointments had been exhausted. The issue was of particular concern to mental health consumers, who often reported that psychology services became unaffordable after the

service limit had been reached, forcing some consumers to either forgo necessary treatment or take on significant financial burden.

Providers and scope of practice

The range of eligible providers and their scope of practice was commonly raised by health professionals, particularly those contributing through the Consultation Hub. This reflects the high proportion of allied health professionals in Consultation Hub responses.

By far the most prevalent concern was that allied health professionals and nurses (including nurse practitioners) should be able to perform a greater variety of MBS services, including providing referrals to specialists or requesting diagnostic tests. In addition, more than 20 nurse surgical assistants argued that MBS rebates should be available for their services in the same way that they are medical health practitioners.

Information—using the MBS

A common frustration with the MBS system was that necessary information was often unavailable or difficult to access. These concerns fell into three areas: the lack of transparency surrounding MBS usage, variation and prices; information on MBS rules and regulations; and information required by consumers to empower them in making decisions about their own healthcare.

Transparency

Transparency surrounding usage, variation and fees was the second most commonly cited priority area for review at the Sydney and Melbourne stakeholder forums, with 45 per cent of participants ranking the issue in the top 5 issues for the Taskforce to review. Stakeholders suggested that more transparent information would assist clinicians in evaluating their own clinical practice. However, they were reluctant for the information to be used for any kind of auditing process.

5.2. Information on MBS rules and regulations

In the Consultation Hub survey, health professionals were asked ‘what would make it easier for health professional and consumers to understand or apply the rules or regulations correctly?’ Overwhelmingly, the answer was greater simplicity either in the rules themselves, or in the explanation of the rules.

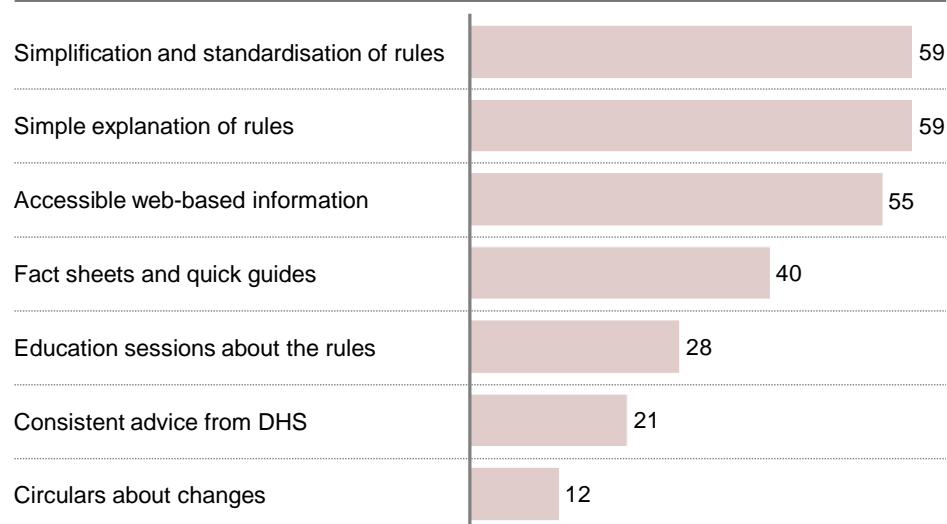
Respondents also wanted information to be accurate and easily available. A number of participants suggested that the Department of Health should produce quick guides tailored to individual areas of practice. This, it was suggested, would remove the uncertainty surrounding MBS rules which may lead to variation in billing practices.

Exhibit 9: APPROACHES TO BETTER UNDERSTANDING OF MBS RULES

What would make it easier for health professionals and consumers to understand or apply the rules or regulations correctly?

Suggested changes to improve understanding of rules

Number of times cited, total 318 responses¹



¹ Respondents were able to provide more than one mechanism; total 335 citations
Source: Consultation Hub

Information required by consumers to be involved in their healthcare decisions

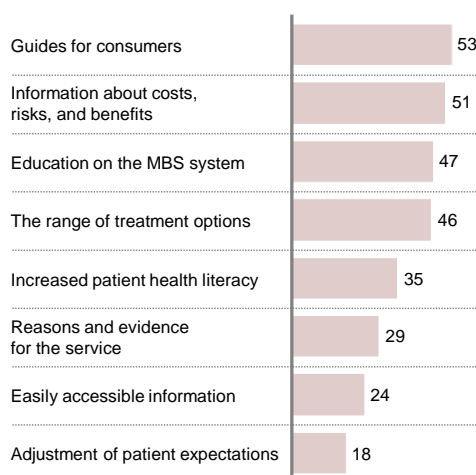
Exhibit 10: IMPROVED CONSUMER INFORMATION

What kind of information do consumers need to better participate in decisions about their health care?

PRELIMINARY

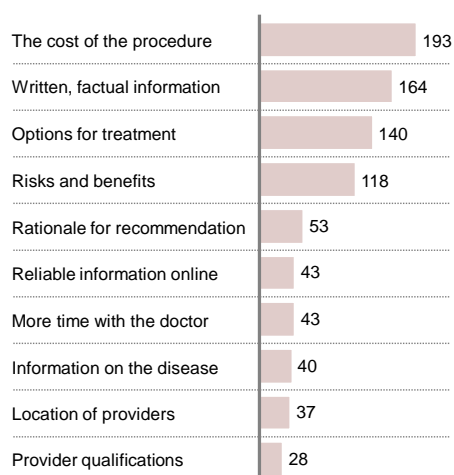
Types of information suggested by health professionals

Number of times cited, total 353 health professional respondents¹



Types of information suggested by consumers

Number of times cited, total 563 consumer respondents²



¹ Respondents were able to identify more than one kind of information; total 483 citations
² Respondents were able to identify more than one kind of information; total 1237 citations
Source: Consultation Hub

Through the Consultation Hub, health professionals and consumers were respectively asked, 'What kind of information do consumers need to better participate in decisions about their

healthcare?’ and ‘What kind of information would be most useful to you in making decisions about the services you receive from health professionals?’

There were a number of similarities in the types of information suggested by consumers and professionals, and how that information should be presented. In relation to the form of the information, both health professionals and consumers emphasised that information should be readily available, clearly written and targeted towards consumers.

In relation to the content of the information, both groups also requested objective, user-friendly information on diseases and injuries, and their diagnosis and options for treatment. Health professionals added that consumers required more information on the MBS system itself.

Moreover, the two groups suggested that information on clinical treatment pathways would be of assistance, including the risks and benefits of the recommended treatment as compared to alternative treatments or ‘watchful waiting’. Many consumers argued that the provision of this type of information would likely require more time with their doctors.

Health professionals and consumers diverged in the type of information requested in two respects. First, consumers were more concerned with informed financial consent, beginning with the diagnosis or GP referral to a specialist. Consumers requested information on fees, as well as rebates and other entitlements for which they may be eligible. While financial consent was addressed by eight per cent of health professionals, nearly 35 per cent of consumer respondents cited this as an issue.

The second aspect in which health professionals and consumers differed was the extent to which the increased involvement of consumers could be addressed by the Department of Health. Health professionals were more likely to suggest that consumers needed to improve their health literacy, a suggestion which would extend beyond the immediate provision of information by the Department.

5.3. Systemic and structural issues

A number of respondents raised concerns about the type of treatment currently incentivised by fee-for-service funding. This issue was initially raised in the July stakeholder forums as one of the overarching changes required for a successful MBS review. Participants at these forums argued that the MBS needed to shift from a system focused on treating sickness, to one focusing on wellness, and from rewarding activities and tasks to rewarding outcomes.

Through the Consultation Hub, many respondents commented that the current system encourages volume, and financially rewards practitioners who carry out more investigations and medical interventions. Consumers provided further detail on the nature of this problem and the serious effect this may have on patient care. For example, one consumer reported that ‘My father had to get six small skin lesions removed by his plastic surgeon. My father wanted to get them done in one session but the surgeon freely volunteered that this did not make enough money for him. So he had to attend twice to get three lesions cut out each session. He had to travel from Gympie to the Brisbane twice and it was also double dipping by the surgeon.’

Complementing the MBS with outcomes-based reimbursement is one possible mechanism to reduce incentives for increased service volumes rather than improved patient outcomes.

Participants at the Melbourne and Sydney stakeholder forums suggested that this was an important issue for the Taskforce. Complementing the MBS with outcomes based reimbursement was the third most commonly cited cross-committee issue at stakeholder forums, with over 40 per cent of respondents placing it in their top five issues. However, respondents were at pains to emphasise that outcomes-based reimbursement should support existing MBS fee structures in appropriate areas, rather than replacing fee-for-service medicine.

6. Feedback on the Review process

6.1 Consultation Hub: Feedback on the Review process

There was broad support for the Review process, with the majority of suggestions for improvement being around the breadth and depth of consultation and engagement. As part of the Consultation Hub survey, health professionals were asked, 'Do you have any comments on the proposed MBS Review process?' Of the 384 responses, 18 per cent expressed enthusiasm and support of the review process, as a 'great idea' and 'long overdue'. 32 percent suggested increasing the breadth and depth of consultation and engagement.

Other commonly raised issues included ensuring that the Review process is evidence based and transparent, and ensuring that the focus of the Review is on consumer outcomes not cost-cutting.

In terms of the breadth and depth of engagement, although respondents recognised the value of a clinically-led review, many respondents pointed to the need to consult with a broader range of stakeholders. Over half of the responses advocating for broader consultation referred specifically to the need to involve more allied health professionals or nurses. For example, one nurse practitioner stated 'I am disappointed that nurses aren't represented on the Advisory Group itself, in addition to being consulted with. They don't appear to have been considered as key players in this space. They shouldn't just be consulted with, they should have the opportunity to lead and drive reform, innovation and change.'

Eighteen respondents based their call for broader consultation on the potential for bias when medical practitioners are evaluating the practices of their colleagues. One health professional suggested 'There is potential issue in placing focus (and strength in numbers) of doctors on the Taskforce and the Committees that the responses will not be from a patient-centred approach as there is a potential vested interest.'

At the same time, several respondents emphasised the need for the review to be supported by the medical profession, for example 'I hope wide consultation with the medical community is undertaken. There is a history of government ignoring the advice of the medical profession and this has had undesirable results.'

6.2 Stakeholder forums: Feedback on the Review process

The need for broad consultation was similarly emphasised at the stakeholder forums, by both participants and the Taskforce.

With regard to consumers, the Taskforce is open to exploring a range of ways of involving them directly, such as focus groups, citizen juries, social media, and case studies, as well as through participation on the Taskforce and its Committees. The Taskforce also discussed the

value of arming consumers with the necessary information prior to consultation, to ensure input was productive. This consultation strategy may be complemented by engaging 'expert consumers', for example through consumer organisations.

For health professionals, the Taskforce discussed the need to leverage traditional channels such as conferences, peak associations, and Colleges. Case studies and written submissions were also discussed, as was the need to provide adequate time for review and response to all draft recommendations.

7 Next steps and plans for further consultation

All feedback on specific items or groups of items will be passed to the relevant Clinical Committee. Each Clinical Committee will be given a dossier of stakeholder input.

The Taskforce will continue to engage stakeholders throughout the Review through further forums, surveys, submissions and targeted discussions with relevant colleges and peak bodies. Stakeholders will be regularly updated on the progress of the Review through the Taskforce newsletter and the Department's website. The Taskforce has also engaged the Consumers' Health Forum of Australia to provide a report on the best way to engage consumers throughout the Review. This will shape the Taskforce's future consultations with consumers.

Open public consultation will also be undertaken on draft Taskforce recommendations, prior to their presentation to the Government.

The initial phase of consultation with key stakeholders provided the Taskforce with insight into a wide variety of experiences with the MBS. The thoughtful and often detailed feedback received is a strong foundation on which to base the MBS Review. The Taskforce would therefore like to thank those who took the time to attend stakeholder forums, provide input to the Consultation Hub or make a formal submission, and hopes that all stakeholders continue their involvement with the MBS Review as it progresses.

Appendix A: Questions included in the Consultation Hub online survey

Questions for a general audience

Q. Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?

Q. Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part the Review as a priority?

Q. Which services funded through the MBS represent high-value patient care and appear to be under-utilised?

Q. Do you have any comments on the proposed MBS Review process?

Q. How can the impact of the MBS Review be evaluated?

Q. Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended?

Q. Are there rules which apply to individual items which should be reviewed or amended?

Q. What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

Q. What kind of information do consumers need to better participate in decisions about their healthcare?

Questions for consumers of MBS services

Q. How has the MBS worked well or not worked well for you or someone you know? Can you give an example?

Q. Have you or someone you know ever had a consultation, medical procedure or test you thought was unnecessary?

If yes, what was the consultation, medical procedure or test and why did you think it was unnecessary?

Q. Have you ever refused or did not have a consultation medical procedure or test because you thought was unnecessary?

If yes, what was the consultation, medical procedure or test and why did you think it was unnecessary?

Q. What kind of information would be most useful to you in making decisions about the services you receive from health professionals?

Q. Have you encountered difficulties with Medicare 'rules'? For example had a Medicare benefit denied, difficulties with referral arrangements, or limits on the number of times you can access certain Medicare services in a year.

If yes, please describe what happened.

Medicare Benefits Schedule Review Taskforce

PUBLIC SUBMISSIONS

SEPTEMBER 2015

CONSULTATION PAPER

Message to the reader from the MBS Review Taskforce Chair

First of all, thank you for your interest in the Medicare Benefits Schedule Review and (hopefully) your input to its modernisation.

We have all been given an important opportunity to contribute to the improvement of our Medicare Benefits Schedule (MBS). As you will discover by reading the attached paper, the MBS is a very important part of our overall health system and it has largely served us well since its introduction in 1984. However in recent years it has become increasingly apparent that the MBS is not always consistent with the latest clinical practice, or the best value healthcare. There are numerous examples that highlight the need for a comprehensive review.

We have designed an approach for the Review to maximise the likelihood of high-quality recommendations being implemented. Rather than a top-down approach, we are calling on many small groups of clinicians, including those operating at the frontline of healthcare, to efficiently and effectively review the available evidence and generate recommendations with input and feedback from consumers and other stakeholders.

This consultation paper and your submissions are an important part of gathering this input. In particular we are looking for examples that you have seen where the MBS seems to be failing to support delivery of best value healthcare. We are also looking for recommended improvements to the surrounding 'rules', processes and systems that support the MBS.

While the MBS Review is a great opportunity, it comes with significant responsibility. Through our consultation processes we hope to enhance our understanding of the cause-and-effect linkages within the health system. In this way we can minimise the unintended consequences of change and design appropriate implementation and transition plans where necessary.

I look forward to reading your submissions and together generating a set of high-quality recommendations that support the best patient outcomes for our health spend.



Bruce Robinson

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Introduction

On 22 April 2015 the Australian Minister for Health, the Hon Sussan Ley MP, announced the formation of the Medicare Benefits Schedule Review Taskforce (the Taskforce) and the Primary Health Care Advisory Group (PHCAG), as part of the Government's Healthier Medicare initiative.

In making the announcement, Minister Ley said that the formation of these groups was in response to overwhelming feedback received during her wide-ranging consultations that Medicare's structure no longer efficiently supported patients and practitioners to manage chronic conditions or the complex interactions between primary and acute care. 'Any reform would need to have a core focus on delivering better patient outcomes, with the Government to engage doctors, patients and other health professionals to lead the broad reform process to ensure that occurs.'

The Taskforce will provide expert guidance to the Government on reshaping the MBS, while PHCAG will advise on aspects of primary care, to better support the quality of Australians' health care and the sustainability of Medicare. These groups are focused specifically on the MBS but will be informed by and form part of the reform agenda in other areas of the health care system as a whole. More information on the Taskforce is available at:

health.gov.au/internet/main/publishing.nsf/Content/healthiermedicare

The current MBS was introduced along with Medicare in 1984, based on earlier schedules dating back to 1953, and has grown significantly in size since then. There are currently 5,769¹⁹ MBS items. The vast majority of these are longstanding, and only a small proportion of the services funded have undergone the type of evidence-based assessment which new services undergo before they can be added to the MBS. 70 per cent of MBS items have not been changed since their introduction, while medical practice has advanced in response to new evidence and new technologies.

The Taskforce will review the MBS in its entirety, considering individual items as well as the rules and legislation governing their application, with the overarching goal of promoting the provision of the best patient outcomes for our health expenditure. Modernising the MBS along these lines will contribute both to the health of all Australians and the long-term sustainability of Medicare.

An important objective of the Review will be curbing inefficiency by ensuring that low-value services—that is, services which provide no or negligible clinical benefit and, in some cases, might actually do harm to patients—cease being funded. This will allow Government investment to be directed to more effective, evidence-based services, maximising the quality and value of the health outcomes delivered by existing Medicare funding and improving sustainability, while also allowing the adoption of new health care technologies—some of which are presently not funded through the MBS but which have already been adopted as best practice.

A key part of this approach will be ensuring that MBS items are evidence-based, fit-for-purpose and reflect contemporary medical practice. An evidence-based MBS underpins best clinical practice and facilitates better health outcomes for patients.

¹⁹ This count is as of 1 April 2015, and excludes the 15 bulk billing incentives items which are administrative items.

The Review Taskforce is aware of the potential impacts of changes in medical practice across the different MBS classifications, for example, where a non-invasive diagnostic procedure supersedes an invasive one. At the same time, the Taskforce is mindful of the potential impact of changes to the MBS on businesses providing health services, and takes this into account in its deliberations.

Key aspects of the MBS Review are that it is clinician led with strong consumer involvement, and involves comprehensive and ongoing stakeholder consultation. The Taskforce commenced this consultation process with a series of stakeholder forums held in July 2015 in Canberra, Adelaide and Perth, and continues with a public submissions process.

The Taskforce

Chaired by Professor Bruce Robinson, Dean of the Sydney Medical School at the University of Sydney, the Taskforce's membership includes doctors working in both the public and private sectors with expertise in general practice, surgery, pathology, radiology, public health and medical administration. Consumers are specifically represented, and there is also academic expertise in health technology assessment.

The Taskforce members are:

Professor Bruce Robinson (Chair)

Dr Steve Hambleton

Dr Matthew Andrews

Professor Michael Besser

Dr Michael Cogle

Associate Professor Adam Elshaug

Professor Paul Glasziou

Professor Michael Grigg

Dr Lee Gruner

Ms Rebecca James (consumer)

Dr Matthew McConnell

Dr Bev Rowbotham

Professor Nick Talley

More information about the Taskforce's activities is available at:

health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce

Vision

The Taskforce proposes that the vision for the MBS be:

The Medicare Benefits Schedule provides affordable universal access to best practice health services that represent value for the individual patient and the health system.

Terms of Reference

At its first meeting in July 2015, the Taskforce endorsed Terms of Reference outlining its work programme. These are:

1. An early, high-level review of the MBS as a whole to identify priority areas taking account of factors including concerns about safety, clinically unnecessary service provision and accepted clinical guidelines.
2. From this high-level review, identify Review topics and assign priority to nominated topics, providing this initial advice to the Minister for Health by late 2015.
3. Commission evidence-based reviews that rely on assessment of literature and data by Working Groups.
4. Analyse the advice from the Working Groups and, in turn provide advice to the Minister, including advice on the evidence for services, appropriateness, best practice options, levels and frequency of support through Medicare.
5. Monitor the outcome of MBS reviews and trends in MBS growth to inform an ongoing cycle of reviews, including advising on a system of ongoing analysis of MBS data, integration of other relevant available data, policy development and implementation.
6. Advise on a departmental programme of work that aims to update the *Health Insurance Act 1973* and regulations (MBS Rules) that underpin MBS funding.
7. Provide advice to the Minister about the MBS and related health financing issues, as appropriate.
8. Engage with health consumers, medical professionals, peak bodies and other stakeholders to seek their views about appropriate review approaches and processes.

Submissions process

The Review provides a timely opportunity to bring the entire MBS into line with current medical best practice, and to introduce processes to keep it up-to-date. The participation of the full spectrum of stakeholders, through this submission process and other channels, has been from the outset a core element of the Review's methodology. Feedback from the stakeholder forums held in July 2015 is summarised at:

www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce

This submission process commences on Sunday, 27 September 2015 and closes at 5.00 pm (Australian Eastern Standard Time), Monday, 9 November 2015.

There are two options for participation in the submission process: an online feedback tool (the Citizen Space Survey Tool) and written submissions. The online tool is available at:

consultations.health.gov.au/medicare-reviews-unit/mbs-review

This has two response streams with different questions in each—one is directed at a broad audience, while the other is directed to people and organisations with a fuller understanding of the MBS. It is designed to collect core information relevant to the Taskforce's work, such as specific MBS items for priority review, as well as more anecdotal comments, especially from consumers of MBS services. This tool's format will assist in the collation of responses for referral to the Taskforce, and makers of written submissions are

strongly urged to complete the Citizen Space questions appropriate for them. On completion of the online tool, the respondent will have the option of uploading a more detailed submission.

Two consultation papers are being released to support this initial MBS Review consultation process, providing information on the context for and objectives of the Review, highlighting issues of particular interest to the Taskforce. This *Consultation paper* is the more detailed of the two, and is intended for a broad audience including health care providers and others with a professional interest in the MBS, who may wish to make a substantive written submission to the Review.

A second paper—the *Consultation paper: Overview*—is essentially a condensed version of this paper, and is intended for an audience with little familiarity with technical aspects of the MBS, including consumers of health services. That audience may wish to limit their contribution to the Review to the online survey, although they have the option of also making a written submission. This paper is available at:

health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce

Submissions must be provided in writing and must identify the name/s of the party/ies and/or organisation/s they represent (if any), as well as contact details. If you have any questions about the submissions process or the Review in general, please contact mbsreviews@health.gov.au or (02) 6289 5151.

All comments and submissions received by the closing deadline will be reviewed and provided to the Taskforce. Submissions may be made public and shared with relevant Commonwealth, State and Territory government agencies to inform consideration of any proposed changes.

Confidentiality of submissions

If you want your submission to remain confidential please mark it as such. It is important to be aware that confidential submissions may still be subject to access under Freedom of Information law.

Background—Medicare and the MBS

The Australian health system overall produces relatively good outcomes by international standards, with Australians enjoying some of the highest life expectancies in the world. Medicare is the Commonwealth-funded health insurance scheme that provides free or subsidised health care services to the Australian population. It was introduced in 1984 as a universal system with the goal of providing Australians with affordable, accessible and high-quality health care. Services under Medicare include:

- fully or substantially subsidised out-of-hospital (non-admitted) services provided by private practitioners such as general practitioners (GPs), specialists, optometrists and, in specific circumstances, dentists and other allied health practitioners;
- subsidised private patient hospital services;
- fully subsidised hospital treatment for public patients in public hospitals; and
- fully or substantially subsidised medicines through the Pharmaceutical Benefits Scheme (PBS).

Principles of Medicare

Universality of access, regardless of a person's financial circumstances, was a core principle of Medicare on its introduction, and remains so. Australian taxpayers contribute to the cost of Medicare through a Medicare levy and, for people on higher incomes who do not have an appropriate level of private patient hospital cover, an additional Medicare levy surcharge is also payable.

Combined revenue from the Medicare levy and surcharge is not allocated directly to health, but is paid into consolidated revenue, and amounts to less than 20 per cent of total Commonwealth health expenditure. In 2011–12, \$9.1 billion was raised by the Medicare levy and surcharge, but the Australian Government spent \$59.5 billion on health overall, including \$17.6 billion on Medicare benefits.

Medicare is a system for the payment of patient benefits, not a remuneration system for doctors. The Schedule fee is not intended to—and cannot—prescribe the payment to the health professional for a particular service. However, the level of benefit for a particular service can influence the billing practices of doctors, particularly for disadvantaged patient groups or in areas of practice where there are high levels of professional and/or geographic competition.

The original aims of Medicare included supporting a fee-for-service structure for a comprehensive range of services, providing health benefit and value for money, and that service provision and pricing should support high-quality service provision.

The Medicare Benefits Schedule

The MBS is a key component of the Medicare system. It lists out-of-hospital services provided by private practitioners as well as private patient in-hospital services, and allocates a unique item number to each service, along with a description of the service (the 'descriptor'). In broad terms, the types of services on the MBS include consultation and procedural / therapeutic (including surgical) services, as well as diagnostic services. Full details of all MBS items, including numbers, descriptors, fees and Explanatory Notes are available from mbsonline.gov.au.

Subsidies for services by eligible health professionals take the form of Medicare benefits paid to the patient. The MBS sets out the 'Schedule fee' for each service and the rate/s at which the benefit for that service is to be calculated, as well as providing guidance on the clinical and administrative conditions under which benefits can be claimed. The rates of benefit are:

- 100 per cent of the Schedule fee for general practitioner services;
- 85 per cent of the Schedule fee for other out-of-hospital services; and
- 75 per cent of the Schedule fee for in-hospital services for private patients.

The Schedule fee is a fee-for-service set by the Australian Government, and may differ from the provider's actual fee. Although Medicare is a public scheme, the health professionals providing the services for which benefits are paid are engaged in private businesses—either self-employed, in partnerships or, increasingly, in corporate entities small and large. Under the Constitution, the right of medical or dental professionals to set fees at their own discretion is guaranteed. The patient is liable for any difference between the MBS benefit for a service and the actual fee charged by the health professional. This difference is known as an 'out-of-pocket' cost.

Where the health professional accepts the patient's assigned Medicare benefit as full payment for the service, there is no out-of-pocket cost to the patient. This is known as bulk billing. The bulk billing rate across all MBS services in 2014–15 was 77.6 per cent. Rates in the same period for specific sectors were:

- GP attendances²⁰ 83.0 per cent
- pathology 87.8 per cent
- diagnostic imaging 76.9 per cent
- optometry 95.4 percent
- specialist consultations 29.9 per cent
- operations 41.6 per cent
- anaesthetics 09.9 per cent²¹

Services covered by the MBS

Currently, MBS benefits are payable for:

- consultations with doctors, including specialists
- tests and examinations by doctors needed to diagnose and treat illnesses, including various imaging services and pathology tests provided by medical specialists
- eye tests performed by optometrists
- most surgical and other therapeutic procedures performed by doctors
- specified dental items under the Cleft Lip and Palate Scheme
- consultations with psychologists
- allied health services for patients with a chronic or terminal medical condition and complex care needs.

MBS benefits are not payable for:

- public hospital and other services funded from another government source (some exceptions)
- pharmaceuticals (except for radiopharmaceuticals)
- dental examinations and treatment
- hospital accommodation
- medical devices and consumables (some exceptions, addressing a lack of public funding sources)
- ambulance services
- home nursing

²⁰ Bulk billing rate for non-referred GP/VR GP. The bulk billing rate for non-referred attendances (Incl GP/VR GP, Enhanced Primary Care, Other, and Practice Nurse Items) was 84.5%.

²¹ Almost all anaesthesia services are provided in a hospital setting, and are therefore not classified as bulk billed even where there is no out-of-pocket cost to the patient.

- glasses and contact lenses
- aids and appliances
- medical services provided overseas
- medical costs for which someone else is responsible (for example a compensation insurer, an employer, a government or government authority)
- medical services which are not clinically necessary
- non-real-time care and non-face-to-face care (some exceptions)
- specifically excluded services e.g. surgery solely for cosmetic reasons
- health screening (some exceptions).²²

Evidence-based funding—The Medical Services Advisory Committee

With the establishment of the Medical Services Advisory Committee (MSAC) in 1998, Australia became the first country in the world to adopt a national evidence-based approach to the public funding of health services. MSAC's principal role is to advise the Australian Minister for Health on evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures. This advice informs Australian Government decisions about public funding for new, and in some cases existing, medical services.

While MSAC's model is international best practice, two gaps exist:

- (i) services listed pre-MSAC, that have not had a comprehensive evidence assessment; and
- (ii) other uses of approved services that may be low value.

The evidence-based approach is designed to achieve a range of outcomes including optimum value for money in the Government's subsidisation of medical services, as well as prioritising the uptake of effective new technologies and procedures while avoiding the premature uptake of unproven technologies and procedures.²³ MSAC is independent of the Government and, while it makes recommendations to the Government about the funding of medical services, MSAC itself cannot implement funding decisions.

Medicare funding and utilisation

Health care in Australia is delivered by a mix of public and private sector entities, and is funded by all levels of government, private health insurers, and out-of-pocket payments by individuals. The Australian Government is not directly involved in health service provision, but funds Medicare benefits, the PBS, and subsidises private health insurance premiums. It also jointly funds public hospitals with the States and Territories and provides financial assistance to residential aged care facilities and home and community care for the aged.

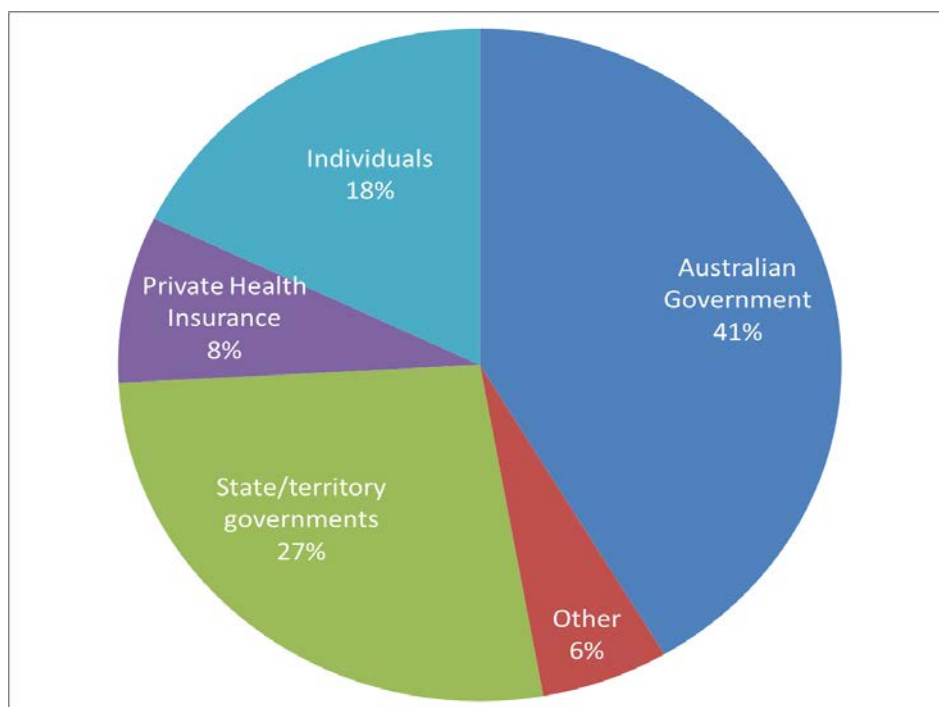
As Figure 1 shows, almost 70 per cent of total health expenditure in Australia is funded by the Australian, State, Territory and local governments. At \$147.4 billion, overall health

²² Medicare Benefits Schedule Explanatory notes pp.34-35
[www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/1BC94358D4F276D3CA257CCF0000AA73/\\$File/201507-MBS.pdf](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/1BC94358D4F276D3CA257CCF0000AA73/$File/201507-MBS.pdf)

²³ Department of Health – MSAC website
www.msac.gov.au/internet/msac/publishing.nsf/Content/home-1

expenditure in Australia in 2012–13 was 9.67 per cent of Gross Domestic Product.²⁴ This is consistent with other OECD countries.

Figure 1: Government and private sector health expenditure 2012–13



Source: AIHW Health Expenditure 2012–13

Medicare is funded from a mix of general revenue including the Medicare levy/surcharge. In 2014–15, \$20.2 billion was paid in MBS benefits (\$843 per capita, up from \$492 in 2004–05). Benefits were paid for 368.5 million services (17 per patient who received a Medicare service, up from 13 in 2004–05), with 89 per cent of the population accessing MBS services. Commonwealth expenditure on Medicare has more than doubled from around \$10 billion a decade ago (not adjusted for inflation).²⁵

In 2014–15, 85 per cent of the population had a GP attendance (including all non-referred attendances), up from 83 per cent in 2003–04. The number of GP services per capita increased in the same period from 5.0 to 5.9. In fact, a standard 'Level B' GP attendance (item 23—less than 20 minutes) accounted for around a quarter of all MBS services in 2014–15 (89.3 million services) and is, by a significant margin, the most utilised of all MBS services.

According to Bettering the Evaluation and Care of Health (BEACH) data, for every 100 GP attendances in 2013–14, there were:

- 49.1 referrals for pathology (an increase from 36.7 in 2004–05)
- 10.9 referrals for diagnostic imaging (an increase from 8.3 in 2004–05)
- 4.9 referrals to allied health (an increase from 2.7 in 2004–05)
- 9.5 referrals to medical specialists (an increase from 7.7 in 2004–05)

²⁴ Australian Institute of Health and Welfare: Health Expenditure Australia 2012-13

www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548869

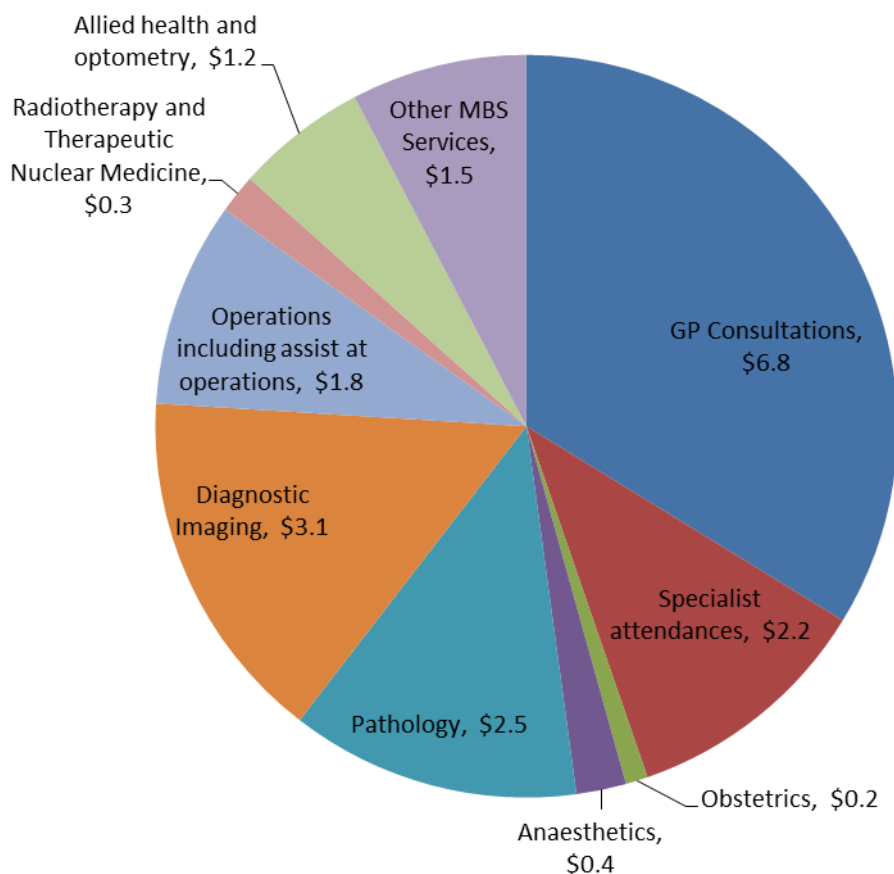
²⁵ Medicare Statistics:

[www.health.gov.au/internet/main/publishing.nsf/Content/34A89144DB4185EDCA257BF0001AFE29/\\$File/MBS%20Statistics%20Financial%20Year%202013-14%20external%2020140718.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/34A89144DB4185EDCA257BF0001AFE29/$File/MBS%20Statistics%20Financial%20Year%202013-14%20external%2020140718.pdf)

One or more of these actions are taken in around 75 per cent of attendances (up from around 55 per cent in 2004–05).

The proportion of the population who received a Medicare pathology test annually increased from 47 per cent in 2004–5 to 54 per cent in 2014–15, with the number of pathology tests per patient increasing from 5.8 to 7.0 in the same period²⁶. The proportion of the population who received a diagnostic imaging service has also increased to 37 per cent from 31 per cent in 2004–05, with the number of services per patient increasing from 2.3 to 2.7.

Figure 2: Medicare benefits paid by type of service 2014-15 (\$ billion)

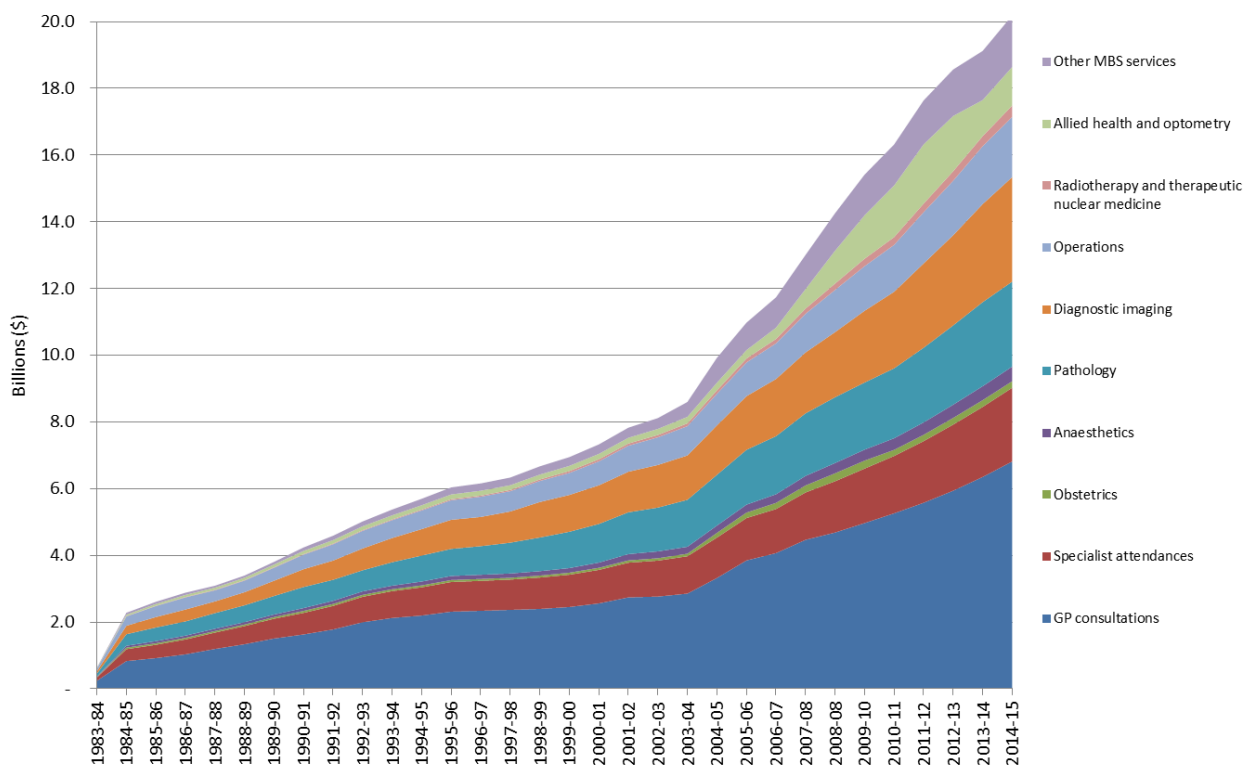


Medicare expenditure

The MBS is an uncapped, demand-driven programme. In general, once a particular service is included on the MBS, its utilisation is largely a matter for health professionals and their clinical decision making in consultation with their patients. There are limited means by which the Government can control the use of individual items, although compliance mechanisms are in place to address obvious instances of misuse. The over-riding principle governing the eligibility of a service for a MBS benefit is that the service must be ‘clinically relevant’—that is, one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient. MBS expenditure since Medicare’s introduction in 1984 is shown below.

²⁶ This only includes pathology services for which a MBS benefit was paid. Note that if the Medicare processing rule known as ‘pathology coning’ is applied to a pathology claim where the tests were requested by GP, benefits are only paid for the services with the three highest MBS fees. If the data for all services affected by the coning rule was collected, this number would be higher. Coning does not apply for in-hospital patients.

Figure 3: Benefit growth -1983–84 to 2014–15 (\$ billion)



Factors contributing to Medicare growth

An increase in the population claiming Medicare

The estimated population of Australia increased from 22.03 million in 2009-10 to 23.95 million in 2014-15 (Estimated Resident Population, Australian Bureau of Statistics), an increase of 8.7 per cent. The number of people receiving Medicare services increased by 9.3 per cent between 2009–10 and 2014–15.

An increase in the age of the population

The median age (the age at which half the population is older and half is younger) of the Australian population has increased by 4.0 years over the last two decades, from 33.4 years at 30 June 1994 to 37.3 years at 30 June 2014. During the same period, the proportion of people aged 65 years and over increased from 11.8 per cent to 14.7 per cent and the proportion of people aged 85 years and over almost doubled from 1.0 per cent of the total population in 1994 to 1.9 per cent in 2014.²⁷

An increase in the average number of services per person

Medicare data show that per capita service use increased from 14.0 services per person in 2009–10 to 15.4 services in 2014-15 (an increase of 10 per cent²⁸). The number of Medicare services per capita for older people is increasing at a higher rate than in other age groups. This is linked in part to the advent of new technologies and techniques which mean that procedures that once carried high risk for older patients can now be safely performed. Increased life expectancy is also a contributing factor in growth in Medicare services and expenditure.

²⁷ Australian Bureau of Statistics, 3101.0 - Australian Demographic Statistics, June 2014

²⁸ Note that if multiple MBS items are claimed on the same occasion for a patient, all claims are counted as services for the purpose of this paper.

An increase in the medical workforce

More doctors equate to greater availability of services and more people accessing Medicare services and claiming Medicare benefits. Between 2009-10 and 2014-15 the number of Medicare-eligible practitioners (including allied health practitioners) grew by over 22 per cent or 21,900 providers. The medical specialty group with the largest increase by head count of practitioners was GPs (all GPs, including non-VR GPs), which increased by about 8,100 or 15 per cent. There have also been significant increases in the specialist workforce.

An increase in the scope of the MBS

As MBS coverage increases, so does MBS expenditure. One notable addition to the MBS was the introduction of funding for allied health services in 2004. Increasing the scope of the MBS has also increased the number of practitioners that can provide Medicare-eligible services. In 2014-15, more than 45,400 'other practitioners', including allied health practitioners such as psychologists, social workers and speech pathologists, and others such as nurse practitioners and midwives provided a MBS service.

The MBS Review

Primary objectives

The MBS Review aims to modernise the MBS to help achieve the following primary objectives:

- best patient health outcomes for MBS expenditure; and
- best evidence-based, clinical practice supported by the health professional services funded through the MBS

Secondary objectives

Where possible, the Review will also seek to make recommendations that progress the following objectives:

- clarify and align expectations of the MBS, including its scope and the rules that underpin MBS payments;
- improve alignment between need for services and access to services;
- optimise interface between MBS funded services, public and private hospitals;
- improve data collection to help inform future health service planning, without increasing red tape;
- sustained implementation; and
- ensure ongoing improvements by designing a process for the MBS to remain current.

The MBS Review approach has been designed to include a number of elements to strongly support achievement of these objectives:

- The Review is clinician led: experienced clinicians as the main source of recommendations for change ensure the highest quality advice while minimising real and perceived conflicts of interest.
- A rapid review process that has been successfully used in Ontario, Canada to ensure we get the balance of quality and efficiency in assessment of evidence right.
- Genuine, thoughtful consultation at key points in the process with all relevant stakeholder groups including the AMA, professional organisations, patient groups

and consumers, to ensure that all key issues have been taken into account.

These objectives and the Review's Terms of Reference have been distilled into six specific activities:

1. Identify and prioritise MBS issues requiring action
2. Triage specific items for review
3. Conduct rapid reviews of items using Clinical Committees, managing Working Groups focusing on specific items (including stakeholder consultation)
4. Recommend changes to item descriptors and/or values
5. Recommend changes to rules and regulations that underpin the operation of the MBS, by a Macro-Issues Committee to address inconsistency, remove ambiguity and enhance compliance (including stakeholder consultation)
6. Embed processes for on ongoing review of the MBS

A number of reviews will be undertaken before the end of 2015, in part to test and refine methodologies for the greater part of the work to be undertaken throughout 2016. The Taskforce will submit its first (interim) report to the Government by the end of 2015 and, as a minimum, a second report by December 2016.

Review process

The major part of the Review will involve the review of MBS items by various Clinical Committees, supported by Working Groups focusing on specific items. More information on this activity is given below. There will also be a review of the rules and regulations that underpin the operation of the MBS, by a Macro Issues Committee.

Clinical Committees

The Clinical Committees will be responsible for advising on the review of a group of related MBS items. Items might be related because of the patient group they affect or the professional group which provides them. Each Committee has a Chair who is a practising expert in that clinical area.

Committee memberships include medical specialists from the relevant discipline/s, as well as other clinicians (including those in related disciplines and generalists), experts in evidence evaluation, and consumers. Members will be required on their appointment to confirm that no conflict of interest (real or perceived) exists, or is likely to arise, in relation to their work on the Committee, and must notify the Department of Health if any conflict does arise.

Clinical Committees will be responsible for considering all the MBS items in their remit and advising on which items are, and are not, in need of more detailed review (as discussed below), as well as identifying items which may need minor amendment and items which are potentially obsolete by virtue of very low utilisation in current practice.

Working Groups

The Working Groups focus on specific issues nominated by the Clinical Committees and/or the Taskforce. Typically, this focus is on individual MBS items or groups of MBS items. The issues referred to Working Groups will be considered with regard to matters such as:

- safety;
- clinical effectiveness;

- cost effectiveness;
- frequency of use;
- the structure of items; and
- aspects of MBS funding that may drive service provision in a suboptimal way.

Where possible, each Working Group is chaired by a member of the parent Clinical Committee. Like the Committees, Working Groups may also include individuals from areas outside the field of medical practice immediately related to the MBS items under consideration, as well as consumer representation.

Rapid reviews

In many cases, the review of MBS items will require an evaluation of the evidence for the relevant service's safety, clinical effectiveness and/or cost effectiveness. Given the Taskforce's remit to review all 5,769²⁹ MBS items in a relatively short timeframe, it will be essential that these reviews are done efficiently, consistent with reliable and useful results. To achieve this, the Review will adopt where appropriate an approach known as the 'rapid review.'

Rapid reviews are conducted when a summary of the evidence for an intervention is required in a very short timeframe—between two and four weeks. The leading exponent of the rapid review process is [Canada's Health Quality Ontario \(HQO\)](http://Canada's Health Quality Ontario (HQO)), which has successfully completed a number of reviews using this methodology. Detailed information is available at: hqontario.ca/evidence/evidence-process/appropriateness-initiative

Rapid reviews employ many of the techniques and tools employed in standard systematic reviews of evidence. A key element of the HQO approach is an initial scoping exercise for each review, resulting in a focused question for the review. Another common feature across HQO reviews is an expert panel for each review. Working Groups would perform this role, ensuring that the review reflects best clinical practice and draws valid conclusions from the available evidence.

A systematic literature search is then conducted to identify relevant systematic reviews, health technology assessments, and meta-analyses. The search prioritises systematic reviews, which, if found, are rated by AMSTAR (Assessment of Multiple Systematic Reviews) to determine their quality. If the systematic review has evaluated the included primary studies using the GRADE (Grading of Recommendations Assessment, Development and Evaluation) Working Group criteria (www.gradeworkinggroup.org/index.htm), the results are reported and the rapid review is complete.

If the systematic review has not evaluated the primary studies using GRADE, the primary studies in the systematic review are retrieved and the GRADE criteria are applied to two outcomes. If no systematic review is found, then randomised controlled trials or observational studies are included, and their risk of bias is assessed.

Scope considerations

Importantly, it should be noted that the focus of the Review is on existing MBS services, although there is scope for amended or new items. MBS items are administrative objects comprising the item number, descriptor, Schedule fee etc., whereas MBS services are the

²⁹ This count is as of 1 April 2015, and excludes the 15 bulk billing incentives items which are administrative items.

actual medical consultations, procedures, tests etc. to which items refer. The Review may well recommend changes to existing items, or the introduction of new items, where these relate to existing services.

The consideration of entirely new services for inclusion on the MBS will be managed as usual by the Medical Services Advisory Committee.

The addition of MBS benefits for new provider groups is outside the Review's scope. Another issue which falls outside the scope of the Review is the allocation between Federal, State and Territory governments of roles and responsibilities in health care.

Public consultation prior to recommendations to Government

A typical Review process will involve an issue being referred from the Taskforce to a Clinical Committee, and then to a Working Group. The Working Group's findings will then be referred back up this line. There may well be variations on this process including, for example, where a Clinical Committee deals with an issue without reference to a Working Group.

A constant feature of the Review will be that the issues raised in findings presented to the Taskforce, including changes to item descriptors and Schedule fees, will be subject to public consultation before the Taskforce makes any recommendations to the Government about actions affecting the MBS.

The Review—Issues for stakeholder comment

The sections following set the high-level context in various areas of the MBS and identify specific issues on which the Taskforce is seeking the views and comments of stakeholders. The 'Online questions' raised mirror the questions in the Citizen Space Survey Tool. The 'Additional issues' raised below are for response in these submissions as appropriate. Respondents may wish to consult the sources of Medicare and other relevant data and information listed in [Attachment A](#).

Parties are encouraged to focus their comments on issues directly related to the Taskforce's objectives. This will not only provide maximum assistance to the Taskforce, but will also avoid unnecessary effort on the part of submitters.

The overall objective of the Australian health system is that people have access to affordable, high-quality health care. The MBS has a key role to play in achieving this objective.

Access and affordability are obviously closely linked, and there are a number of factors which can have an impact. Affordability affects access through out-of-pocket costs. These are more likely to be zero or low for GP, diagnostic imaging and pathology services, and more likely to be higher for specialist services. Equally importantly, Australia's size and population distribution mean that a person's geographic location alone might make physical access to MBS services difficult if not impossible.

The MBS is based on fee-for-service, where patient benefits are paid for specific activities. While administratively simple, and providing strong incentives for access and efficiency, a fee-for-service approach also promotes emphasis on activity rather than outcome, and episodic rather than coordinated, multidisciplinary care.

The current system largely links payment to an interaction between a doctor and a patient, when the actual service involved might be provided by another health practitioner employed by the doctor.

For instance, although there are a variety of case conferencing items on the MBS, it is very likely that these are not used optimally because they do not engage smoothly with a model that is based on intermittent interactions between a clinician and a patient.

One of the issues already identified by stakeholders is the growing use of multiple items for one episode of care provided on the same day by one practitioner. This can seem unfair both for patients, if it does not meet with their expectations, and providers, as different total benefits apply for what are similar services.

There is a view that an item (particularly in surgical practice) should, where possible, represent a 'complete medical service'. However, there is evidence of considerable variation between providers in how item numbers are used for the same service.

It may be useful to consider introducing bundled payments for some specialist services, where care continues over a discrete period of time. This approach is used now in assisted reproductive technology services and could be contemplated in areas such as obstetrics and some cancer treatment services.

Online questions

Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?

Do you have any comments on the proposed MBS Review process?

Additional issues

Should the role of the MBS be simply that of an administrative tool, or should it be used actively to guide quality medical practice?

What can be done to reduce unexpected variation in the MBS items claimed for similar services?

What implementation issues should be considered when amending or removing MBS items?

Are there any other principles that must guide the Review?

Evaluating the MBS Review

The Taskforce's over-riding objective is to improve the value that is derived from MBS expenditure. An important issue to consider, therefore, is how the success of the Review in achieving this can be evaluated.

The Medicare system generates large volumes of data about benefits paid for (in-scope) health services delivered to Australians. In parallel, the health system more broadly gathers information about patient health outcomes. The difficulty is in reliably linking MBS services and items to these health outcomes given the many other contributing factors.

With this in mind, potential process measures of the Review's effectiveness might include:

- the number of reviews completed; and
- the proportion of MBS items reviewed.

Online questions

How can the impact of the MBS Review be measured?

What metrics and measurement approaches should be used?

How should we seek to improve this measurement and monitoring capability over time?

Need for evidence-based reviews

One of the Review's key objectives is to eliminate the funding of low-value or inappropriate health services—that is, treatments, procedures and tests which are of little or no clinical benefit, through overuse or misuse, and which in some cases might actually cause harm. There are three potential indicators of possible low-value care. The first is where treatments that are proven to be of low or no clinical benefit for individuals with certain clinical characteristics continue to be provided. The second is extreme variation in the provision of care across different settings. The third is where an otherwise effective test or investigation is performed at an inappropriate interval or frequency (e.g. too often). This category includes the unnecessary duplication of testing.

The obvious way to address the problem of low-value services is to ensure, to the greatest extent possible, that services used appropriately are eligible for funding while inappropriate uses are not eligible. That is one of the major challenges facing the Review.

The evidence suggests that a number of services on the MBS fall into the category of low-value care. A paper published in the Medical Journal of Australia in 2012, *Over 150 potentially low-value health care practices: An Australian study*³⁰, identifies 156 potentially ineffective and/or unsafe services listed on the MBS.

A recent report by the Grattan Institute³¹ identifies treatments which should not be used on certain patients. While this report focuses on hospital care, three of the services identified are covered by MBS items. They are:

- arthroscopic debridement for osteoarthritis of the knee (inserting a tube to remove tissue);
- laparoscopic uterine nerve ablation for chronic pelvic pain (surgery to destroy a ligament that contains nerve fibres); and
- removing healthy ovaries during a hysterectomy.

The report found that these treatments are being provided in higher numbers than the evidence suggests they should be, and often to patients who should not receive them. There is also significant variation in their provision between the States and Territories.

Another facet of the variation issue is where there is marked variation across geographic areas for services whose efficacy is not generally open to question, including common surgical procedures. It can be problematic determining the cause of these variations and on

³⁰ Adam G Elshaug, Amber M Watt, Linda Mundy and Cameron D Willis, *Med J Aust* 2012; 197 (10): 556-560.

³¹ Duckett, S., Breadon, P., Romanes, D., Fennessy, P., Nolan, J., 2015, *Questionable care: Stopping ineffective treatments*, Grattan Institute

which side of the relationship the inappropriate practice is occurring—that is, whether the patients in the high-use area are receiving too many services, or the patients in the low-use area are receiving too few.

In Australia and internationally, considerable effort is being directed to identifying and reducing the use of low-value health care services and practice. The *Choosing Wisely* initiative is a notable international campaign aimed at eliminating unnecessary treatments, procedures and tests. Originating in the US, *Choosing Wisely* programmes now also operate in Australia and Canada, with similar schemes being established in Germany, Italy, Japan, the Netherlands, and Switzerland. Similarly the EVOLVE campaign led by the Royal Australian College of Physicians is bringing together medical specialists in a grassroots campaign to identify low value activities with the goal of positively modifying clinical practice.

The Choosing Wisely approach is founded on the principles of managing conflicts of interest, improving the quality of care, improving access to care, and promoting the just distribution of finite resources. It brings together clinicians and consumers and considers services which are of questionable value, to inform the decisions of clinicians and to empower consumers to participate in conversations with their doctor about their care.

These initiatives challenge the idea that, in health care, more is always better. One of the problems with a fee-for-service system like the MBS is that there is a financial incentive to provide more services, but little incentive to diagnose without testing, even where this is established to be best practice, and no financial disincentive to minimise the provision of low-value services.

Finally, internationally there is growing interest among clinical communities in defining the ‘appropriate use criteria’ accompanying certain practices. These criteria define characteristics of patients for whom particular care is most appropriate, and for whom that care ought not be provided (at all or at a given frequency, etc.). These criteria have been built by expert groups using data from health outcomes and economics research to inform (i.e. define) circumstances (patient, time, place) where care represents high versus low value.

Online questions

Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part of the Review as a priority?

Which services funded through the MBS represent high-value patient care and appear to be under-utilised?

Additional issues

Should cognitive (clinical diagnostic) services receive priority attention?

MBS legislation and ‘rules’

Medicare and the MBS are underpinned by various pieces of legislation and it is part of the Taskforce’s role to review and recommend updates to these. The *Health Insurance Act 1973* (the Act) in particular sets out the broad principles and definitions governing the MBS. For

example, it stipulates that Medicare benefits are payable for professional services, defined as ‘a clinically relevant service to which a MBS item applies’. A ‘clinically relevant service’ is defined as ‘a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.’ⁱ

The Act also sets out eligibility criteria for health care providers wishing to provide Medicare-eligible services, and prohibits the payment of benefits in certain circumstances (e.g. for services which are wholly or partly funded from another government source).

Section 4 of the Act provides that regulations may prescribe tables of medical services—covering general medical services, diagnostic imaging and pathology—which set out item descriptors, the Schedule fee for each item, and rules for interpreting the table. These ‘table’ regulations, which are remade annually, prescribe the items which are replicated in the MBS and provide definitive advice on its operation—the Explanatory Notes in the MBS itself have no legal force. Below is a summary of the main Acts and regulations in operation for the payment of Medicare benefits.

Acts

Health Insurance Act 1973

National Health Act 1953

Private Health Insurance Act 2007

Regulations

Health Insurance Regulations 1975

Health Insurance (General Medical Services Table) Regulations 2015

Health Insurance (Diagnostic Imaging Services Table) Regulations 2015

Health Insurance (Pathology Services Table) Regulations 2015

The Review presents an opportunity not only to assess the clinical efficacy of specific services, but also to consider broader questions about the role of the MBS and the rules in MBS legislation which give effect to this role at a practical level. Some of these rules have been in place since Medicare’s introduction.

Some rules may reflect medical practice at a particular point in time and be sensitive to changes in practice. Difficulties can arise in ensuring that these rules remain consistent with current medical practice, and in ensuring that a rule intended to enforce a principle does not in practice impose undue hardship on providers or patients. One example often raised by consumers is the rule placing a three-month limit on specialist-to-specialist referrals. While the intention was to strengthen the role of the GP as gatekeeper to secondary health care, the consequence is that patients need to seek additional consultations, often clinically unnecessary, simply to renew their referral. Voluntary enrolment is being considered by PHCAG and, with better use of digital health to keep the GP informed, time-limited referrals could be re-examined as part of the Review. Other examples of current rules include:

- The requirement that health practitioners request or refer for diagnostic and pathology tests (patients cannot self-initiate these services)—other rules stipulate who can provide these tests.
- The information requirements for a Medicare benefit claim form (such as patient details) before the claim is accepted and processed.

- Restrictions on the MBS items which can be claimed for the same patient on the same occasion of care.
- Criteria for services which can be provided only in a hospital, or under the auspices of a hospital.
- Arrangements for the payment of MBS benefits for an assistant or anaesthetist at surgery.
- Compliance rules for managing inappropriate or fraudulent claiming through the Professional Services Review.
- Circumstances under which MBS benefits are not payable, such as where a service is provided under an arrangement with the Commonwealth or a State or Territory government.

Even prior to the introduction of Medicare, there was a strong view that there are certain types of low or zero value medical services which should not be publicly funded. Some of these services fall into the broad category of 'health screening services'. Concerns around these services remain, particularly when their provision may be driven by entrepreneurial practice models which are not concerned with ongoing patient care.

Since 1978 the *Health Insurance Act 1973* has included a specific prohibition against the payment of benefits for health screening services. However, since that time health prevention activities have become a core component of general practice and there may be confusion between a health screening service as contemplated at the inception of Medicare and clinically necessary prevention activities such as cancer screening and cardiovascular risk modification.

Online questions

Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

Are there rules which apply to individual MBS items which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

Additional issues

Are there existing rules which are causing unintended consequences or are outmoded and should be reviewed?

Are there alternative solutions to deliver the original intent?

In amending any existing rule/s, are there any potential adverse impacts on consumers, providers or government?

Are there any new rules which should be introduced?

Are there medical services which should not be funded for reasons other than concerns about safety and/or clinical efficacy? How can these be defined unambiguously?

MBS/public hospital interface

It is a central tenet of Medicare that Australians have the right to choose to be treated as a public patient in a public hospital, free of charge. This principle is enshrined in the National Health Reform Agreement between the Commonwealth and the States and Territories. Private patients in public or private hospitals, on the other hand, will be charged for their accommodation and treatment and are able to access MBS benefits and private health insurance to assist in meeting these costs. MBS benefits are not, however, available for public patient services.

Subsection 19(2) of the Act prohibits the payment of Medicare benefits for services provided under an 'arrangement' with the Commonwealth, the States and Territories, and a range of other bodies. Ss19(2) is intended to prevent a range of 'double dipping' scenarios, where a single service is funded twice—through a MBS benefit and also through some other form of government funding. However, it has long been the case that salaried medical practitioners working in public hospitals can also see their own patients under rights of private practice, and it is permissible to claim Medicare benefits for these services.

The evolution of these practices and the lack of transparency across the system mean again that different benefits flow to different patients for the same service, depending on local practice. Broader issues around public hospital funding are being considered through the Government's Reform of the Federation White Paper.

Compliance

As well as the activities of the Taskforce and PHCAG, the Healthier Medicare initiative also includes a programme of work to develop clearer Medicare compliance rules and benchmarks. 'Compliance' here refers to the compliance of health care providers with legislative, clinical and ethical requirements relevant to the MBS and the PBS. In the present context, however, the focus is exclusively on the MBS.

The objective of the compliance programme is to control fraudulent or clinically inappropriate behaviours among providers, and minimise the inefficient or unlawful payment of MBS benefits. This approach is central to the Government's objective of reducing waste in MBS expenditure. The outcomes of compliance activities can also inform the design of health policies and programmes, including the refinement of existing MBS items.

The compliance programme is managed jointly by the Department of Health, the Department of Human Services (DHS) and the Professional Services Review (PSR). The compliance programme must be flexible enough to achieve its objectives while allowing practitioners to exercise reasonable clinical and professional judgement and to allow benefits to be paid with minimal up-front verification so that patients can access affordable health services readily. To achieve this, a tiered approach to compliance is used, with administrative compliance activities (audits and reviews) undertaken by DHS and a complementary peer review scheme managed by the PSR. There are three key areas on which compliance activity focuses:

- Deliberate fraud, where an individual seeks to obtain a Medicare benefit by intentionally falsifying facts and/or documents. This generally involves a Medicare claim being lodged where a service was not provided, or a service being provided which does not meet the requirements of the Act and/or relevant regulations.
- Inappropriate practice, where a service is provided which is not clinically appropriate.
- Incorrect Medicare billing, where a practitioner unintentionally makes a false or misleading statement that results in a Medicare benefit being paid that is greater than the benefit which should have been paid.

Medicare systems include a number of up-front checks for every claim that is lodged (e.g. that the patient is Medicare eligible, that the doctor is a recognised practitioner, that the service is identified and item-level rules are met) before a claim is paid. Additionally, post-payment activities are undertaken by DHS which consider broader provider claiming patterns and behaviours. There are two streams:

- Medicare compliance audits and reviews, which essentially look at business processes and rules; and
- Practitioner Review Programme (PRP), which looks at clinical behaviours. Potentially inappropriate practice can be referred to the PSR for investigation. It is important to note that the '80/20 rule' requires DHS to automatically refer certain practitioners to the PSR where they have rendered 80 or more professional attendances on 20 or more days in a 12-month period.

Access to MBS data

Monitoring of MBS activity by the Departments of Health and Human Services generates a great deal of data in a range of areas, including:

- the utilisation of individual MBS items and the benefits paid, both on a broad, population-based level and also in relation to specific episodes of care;
- MBS utilisation by particular groups of providers and in particular fields of practice;
- the MBS claiming and billing patterns of individual practitioners, including bulk billing rates and out-of-pocket charges; and
- the geographical distribution of MBS activity.

These data allow analysis of long-term trends, modelling of future activity, and the monitoring of individual provider behaviour for compliance purposes. Importantly, it also allows the examination of specific services—their use in isolation, but also in conjunction with other services and their role in current medical practice. While MBS data is unarguably valuable, there is an administrative input required of providers to produce it, and the need for data must be balanced with this burden on providers.

The data collected is adequate for Medicare reporting purposes and for evaluating the impact of changes to existing arrangements. However, there are a number of limitations on the current treatment of MBS data, and on its interaction with other data sets, which constrain its potential value to administrators, consumers, researchers and public health clinicians.

MBS data is not readily linked with data from other components of the health system, including the PBS and hospitals, so it is currently impossible for a single ‘observer’ to follow the complete clinical pathways of patient cohorts through the health system. Also, while the quality of MBS services is addressed through measures such as provider credentialing and practice accreditation, it is difficult to assess the success of these measures because of the lack of patient outcomes data for MBS services.

The potential value of MBS data to consumers is also not being fully exploited. In particular, information on the variation of billing practices between providers (potentially de-identified but provided in a geographically meaningful way) could be useful in making decisions about, for example, which specialist to see.

One concern that has been raised by stakeholders is that while the MBS as an administrative data set offers significant insights into what services have been provided and paid for, there is a lack of information about why a patient required a service and what the outcome was. If this additional information were routinely collected and available (de-identified) for analysis, it could provide evidence to improve health policy in a range of ways—for example, better evidence to inform future reviews, the ability to identify patient groups who should be receiving additional care, or the ability to earlier identify the emergence of an epidemic.

However, the acquisition of more useful data through the MBS would generally require more detailed and prescriptive item descriptors, and possibly a greater number of items applying to the same service than is currently the case. This approach is at odds with the idea of a simpler MBS with less prescriptive item descriptors, allowing practitioners greater latitude in delivering a service. This approach has advantages for practitioners and is consistent with the Government’s deregulation agenda, but is not conducive to the generation of detailed data.

A current example of an outcomes-focused item is obstetrics item 16519, for which the descriptor is: ‘Management of labour and delivery by any means (including Caesarean section) including post-partum care for 5 days.’ An example of a more complex item is 11820 for capsule endoscopy, with the descriptor:

Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if:

- (a) the patient to whom the service is provided:
 - (i) has recurrent or persistent bleeding; and
 - (ii) is anaemic or has active bleeding; and
- (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and
- (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and
- (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy; and
- (e) the service is not associated with balloon enteroscopy.
- (f) the service has not been provided to the same patient:
 - (i) more than once in an episode of bleeding, being bleeding occurring within 6 months of the prerequisite upper gastrointestinal endoscopy and colonoscopy (any bleeding after that time is considered to be a new episode); or
 - (ii) on more than 2 occasions in any 12 month period

Online question

What kind of information do consumers need to better participate in decisions about their health care?

Additional issues

Should the MBS be used to encourage more systematic collection of data?

Are there MBS items which could have health outcomes data readily linked to the provision of health care?

Should MBS items support participation in the creation or development of other data sources? e.g. myHealth Record, clinical trials, funding linked to evidence production.

Consumer experiences

Consumer expectations can have significant influence on Medicare utilisation. The typical patient presenting for a consultation with a health professional is not, understandably, aware of or concerned about questions of health system efficiencies or the economics of Medicare funding. They are focused on their very particular concerns and are usually motivated by no other desire than to improve or cure their existing medical condition, or to have their fears about a suspected condition allayed, at minimal out-of-pocket cost. Consumers have different levels of health literacy and confidence, which will affect their ability to question the value of suggested tests or procedures or ask about any associated risks.

In addition, the vast expansion in online information sources, with widely varying levels of authority and reliability, means that many patients arrive for a consultation with certain preconceptions about their actual or suspected condition and the appropriate course of clinical action. This can, for example, place pressure on doctors to request tests they might not otherwise request.

Consumers also often find it difficult to get clear information about how much particular services cost, with the total cost, the Medicare benefit, the private health insurance contribution (where applicable) and the out-of-pocket costs sometimes hard to understand. This can affect their ability to make decisions about their care. Even when consumers do not face any out-of-pocket costs, they may want to understand the cost to Medicare of the service they have received.

Online questions for consumers of MBS services

How has the MBS worked well or not worked well for you or someone you know? Can you give an example?

Have you or someone you know ever had a consultation, medical procedure or test you thought was unnecessary? If yes, what was the medical procedure or test, or what was the consultation for, and why did you think it was unnecessary?

Did you raise this with your doctor?

Have you ever refused or did not have a consultation, medical procedure or test because you thought it was unnecessary? If yes, what was the medical procedure or test, or what was the consultation for, and why did you think it was unnecessary? Did you raise this with your doctor?

Have you encountered difficulties with Medicare 'rules'? e.g. had a Medicare benefit denied, difficulties with referral arrangements, or limits on the number of times you can access certain Medicare services in a year. If yes, please describe what happened.

What kind of information would be most useful to you in making decisions about the services you receive from health professionals?

Additional issues

What roles and responsibilities do consumers have in facilitating the best value use of Medicare services?

ATTACHMENT A - Source of Medicare data

Sources of Medicare data

[MBS items statistics reports](#)

(medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp)

Monthly, quarterly, yearly services and benefits statistics by item, broad type of service (BTOS), group and demographic

[Department of Health annual Medicare statistics](#)

(www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-statistics)

Annual services, benefits, bulk billing, Schedule fee observance and patient contribution rates by BTOS, state, city, rurality, gender, age

[Department of Human Services annual report](#)

(humanservices.gov.au/corporate/publications-and-resources/annual-report/resources/1314/)

Medicare levy exemptions, annual services and benefits, billing type, Practice Incentive Programme payments, practice nurse payments, rural health incentives

[My Healthy Communities—National Health Performance Authority](#)

(myhealthycommunities.gov.au/)

Services per patient, GPs per patient, hospital visits, expenditure by patient with high/low visits, state, rurality, age, chronic disease status

[Australian Institute of Health and Welfare—Health expenditure 2012–13](#)

(aihw.gov.au/expenditure-publications/)

Yearly services, benefits, out-of-pocket costs, government health expenditure, GDP, inflation, expenditure per person

[National Centre for Geographic and Resource Analysis in Primary Health Care](#)

(graphcdev.aphcri.anu.edu.au/RMT_au/MABEL/index.html)

Interactive Australia-wide maps on GP profiles, practice profiles, GP services and population statistics by Medicare Local and year

[My Hospitals](#) (myhospitals.gov.au/)

Hospital performance, waiting times, length of stay for elective surgery, emergency visits

Population data

[Australian Bureau of Statistics—Patient experience survey](#)

(abs.gov.au/ausstats/abs@.nsf/mf/4839.0)

Waiting time and number of visits for GPs, hospitals and specialists, ability to pay health costs, satisfaction with care by age and gender

[Australian Health Survey](#) (abs.gov.au/australianhealthsurvey)

ABS data on diet, exercise, health profile, health service usage, for the general population and Indigenous and Torres Strait Islanders

[45 and Up Study](#) (saxinstitute.org.au/our-work/45-up-study/data-book/)

Smoking status, drinking status, weight, height, family history, medications, chronic disease, physical activity, health rating, food consumption by age, gender

[Department of Social Services concession card statistics](https://data.gov.au/dataset/dss-payment-demographic-data) (data.gov.au/dataset/dss-payment-demographic-data)

Number of concession card holders by state, gender, marital status, age, indigenous status, postcode. Duration on income support, payment by rate, earnings by concession card

[Federal electorate data](https://infoaus.net/seifa/fed_electorate.php) (infoaus.net/seifa/fed_electorate.php)

MP, population and socio-economic indexes for areas (SEIFA) distribution by Federal electorate

[My Healthy Communities](https://myhealthycommunities.gov.au/) (myhealthycommunities.gov.au/)

Provides information down to the Medical Local area including statistics on health status, hospital admissions and MBS items usage for GP services

Private health insurance data

[Private Health Insurance Administration Council](https://apra.gov.au/Pages/phiac-redirect.aspx) (apra.gov.au/Pages/phiac-redirect.aspx)

Statistical trends in membership, benefit data by year

[Private health insurance funds information](https://privatehealth.gov.au/) (privatehealth.gov.au/)

Information on private health funds; data on who and what is covered, and what is included in competing policies

International data

[OECD health spending](https://data.oecd.org/healthres/health-spending.htm) (data.oecd.org/healthres/health-spending.htm)

International comparison of health expenditure (total, per capita, proportion of GDP), life expectancy, mortality, health determinates, health service usage

[Commonwealth Fund—Health system publications](https://commonwealthfund.org/publications/view-all-reports-and-briefs#/first=0&sort=@fdate12610%20descending&f:@ftopicsfacet12610=%5BHealth%20System%20Performance%20and%20Costs%5D)

(commonwealthfund.org/publications/view-all-reports-and-briefs#/first=0&sort=@fdate12610%20descending&f:@ftopicsfacet12610=%5BHealth%20System%20Performance%20and%20Costs%5D)

US-based international comparisons. Features comparisons of effectiveness and expenditure of health services

APPENDIX D - Providers of submissions 2015

MBS Review—Providers of submissions 2015

Lists of providers
Alere
Alliance for Better Access
Allied Health Professions Office of Queensland
Alzheimers Australia
Arthritis Australia
Audiology Australia
Australasian College for Emergency Medicine
Australasian College of ENT Physicians
Australian & New Zealand Council of Chief Nursing and Midwifery Officers
Australian & New Zealand Society for Geriatric Medicine
Australian & New Zealand Society for Vascular Surgery
Australian Association of Developmental Disability Medicine
Australian Association of Social Workers
Australian College of Advanced Postgraduate Psychologists
Australian College of Nurse Practitioners
Australian College of Nursing
Australian College of Rural & Remote Medicine
Australian Day Hospital Association
Australian Dental & Oral Health Therapists Association
Australian Dental Association
Australian Diagnostic Imaging Association
Australian Federation of AIDS Organisations
Australian Health Service Alliance
Australian Healthcare & Hospitals Association
Australian Institute for Genital Autonomy
Australian Medical Association
Australian Nursing and Midwifery Association
Australian Orthopaedic Association
Australian Physiotherapy Association
Australian Primary Health Care Nurses Association

Lists of providers
Australian Private Hospitals Association
Australian Psychological Society
Australian Society of Anaesthetists
Australian Society of Orthopaedic Surgeons
Australian Society of Plastic Surgeons
Avant Mutual Group
Baker IDI Heart & Diabetes Institute
Bayer Australia
Beenleigh Sleep Clinic
BUPA
Carberry Counselling
Charles Sturt University
CHILD Association
Chiropractors' Association of Australia
Combined Pensioners and Superannuants Association
Committee of Presidents of Medical Colleges
Congress of Aboriginal & Torres Strait Islander Nurses & Midwives
Consumers Health Forum of Australia
Counsyl
CQ University
CRANA Plus
Curtin University
Dental Health Services Victoria
Diagnostic Imaging Pathways
Doctors Against Forced Organ Harvesting
Exercise & Sports Science Australia
Faculty of Clinical Radiology
Family Planning Victoria
Flinders University
General Practice Mental Health Standards Collaboration
GenesisCare

Lists of providers
George Institute for Global Health
Gowan & Associates
Griffith Health
Gut Foundation
HIRMAA
Hunter New England Central Coast PHN
Isolated Children's Parents' Association of Australia
Johnson & Johnson
LORICA Health
Macquarie Medical Imaging
Macquarie University Hospital
Maternity Choices Australia
Medibank
Medibank Private
Medical Sleep Testing
Medicines Australia
Medtronic Australasia
Mental Health Carers Arafmi Australia
Midwifery and Maternity Provider Organisation of Australia
MonashHeart
National Association of Practising Psychiatrists
National Association of People with HIV Australia
National Blood Authority
National Coalition of Public Pathology
National Heart Foundation
National LGBTI Health Alliance
National Seniors Australia
NATSIHWA / ANON-RN8J-P4BR-T
Northern Health Network
NSW Health
NT Government

Lists of providers
Occupational Therapy Australia
Ochre Health
Optometry Australia
Orygen
Osteopathy Australia
Pain Australia
Palliative Care Australia
Pathology Australia
Patient Blood Management Steering Committee
Pharmaceutical Society of Australia
Primary Health Care Limited
Private Healthcare Australia
Queensland Health
Queensland Sleep
Queensland University of Technology
Radiation Oncology Victoria
RAMS
Reflexology Association of Australia
Rehabilitation Medicine Society of Australia and New Zealand
Royal Australian & New Zealand College of Radiologists
Royal Australian College of General Practitioners
Royal College of Pathologists of Australasia
Rural Doctors Association of Australia
SA Health
SANE Australia
Services for Australian Rural and Remote Allied Health
Smith & Nephew
Society of Hospital Pharmacists of Australia
Specsavers
Speech Pathology Australia
St Jude Medical

Lists of providers
Telstra
Thoracic Society
University of Sydney
University of Tasmania
Victorian Child Psychotherapy Association Training Committee
Victorian Refugee Health Network
WA Health
Western Respiratory & Sleep Clinic
