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Professor Bruce Robinson
Chair
Medical Benefits Schedule Review Taskforce
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Dear Professor Robinson

RE: Medicare Benefits Schedule (MBS) Review – Urology clinical committee report and the maximum three item rule.

I am writing to provide feedback on the report from the Urology Clinical Committee (UCC), that was received in September as part of the MBS Review Taskforce's targeted consultation.

The AMA has consulted with Urological Society of Australia and New Zealand (USANZ), urologists and other medical practitioners potentially impacted by the maximum 3-item rule. The AMA notes that, as well as being the peak professional body for urological surgeons in Australia and New Zealand, USANZ also administers the Surgical Education and Training Program in Urology for the Royal Australasian College of Surgeons. Accordingly, I'm aware that USANZ is responding in detail to the UCC report recommendations, reflecting its specialist expertise.

As always, the AMA defers to the relevant College, Association and Society on specific clinical matters. We call on the Government to engage with the key stakeholders should any of these groups identify significant clinical concerns with the proposed changes to the MBS.

The AMA supports USANZ in its strong and categorical opposition to the introduction of the maximum 3-item number rule for the urology surgical MBS items. The application of this rule, which is being used to cap the maximum number of items, claimable by a single surgeon during one surgical procedure to 3 items (per side) is, the AMA believes, simply a savings measure.

The UCC report (page 19) states that the maximum 3-item rule recommendation is based on the Taskforce's rationale that, the majority (94 per cent) of MBS benefits paid are for episodes where three or fewer items are claimed, and that the remaining claims lack transparency and have greater inter-provider variability. The AMA notes that the UCC report does not explore whether the inter-provider variability is clinically appropriate and what is meant by lack of transparency.

Whilst the AMA understands and agrees with the principle of a complete medical service, the maximum 3-item rule has an unsound basis and appears to be simply a savings measure. To suit this arbitrary rule, the profession is being forced into agreeing to combinations of item numbers and in practical terms, these combinations, cannot represent all clinical situations. The 3-item recommendation does not meet the goals of the MBS Review of aligning with contemporary clinical evidence and practice or improving patient health outcomes. Instead, the recommendation has a significant risk of unintended consequences such as increased out of pocket costs for patients.

The AMA has received compelling feedback from a large section of the profession across multiple specialties, that the 3-item rule itself is not currently accepted as a fair or workable option. This stance is reiterated by the USANZ in its response to the UCC report:

> *"The 3-item number rule is impractical and unworkable. Much effort has been put into modifying the Urology section of the Medicare Benefit Schedule to conform with the proposed 3-item number rule.*
>
> *Diseases and medical conditions do not, however, conform with Government edicts such as the 3-item number rule. It is impossible to predict all permutations and combinations of item numbers that will be required in a single surgical episode of patient care.*
>
> *The decisions regarding optimal clinical care and surgical treatment must be left up to the treating clinician rather than dictated by compliance with the 3-item number rule within the Medicare Schedule."*

It is deeply concerning to the AMA that, whilst the MBS Review Taskforce Principles and Rules Committee (PRC) deferred its decision regarding the three-item rule due to consultation feedback, this recommendation has been taken forward and applied in the UCC report without regard or reference to this feedback.

I bring your attention to my letter of 3 November 2018 where I initially raised this issue. Unfortunately, at the time of writing this letter the AMA has yet to hear back from you regarding this issue. I have reattached my letter for your active and timely consideration.

The AMA again seeks assurances that the 3-item rule is open for further discussion. That the MBS Taskforce will coordinate with the affected Colleges, Associations and Societies to come to mutually agreeable changes; that are consistent and reasonable, work across the specialties; that align with contemporary clinical evidence and practice and improve health outcomes for patients.

Until such agreement is reached, the AMA believes that this report should be revised by the clinical committee and that they should not be constrained by the 3-item rule. Instead they should be allowed to determine what is best clinical practice and what will deliver the best health outcomes for Australians – not what will deliver Government the greatest amount of savings.

MBS item cost savings and cost neutrality

As the AMA consistently reiterates, the MBS Review must not be a savings exercise. Any savings must be reinvested in Medicare and that investment should be in the form of increased rebates, new items and a more contemporary system. Funding increased volume and indexing Medicare merely keeps the system afloat – the savings from the review needs to be invested above and beyond the business as usual responsibilities of government. Sadly, Senate Estimates in May 2018[1] has confirmed that of the net savings of $600 million generated from the MBS Review to date, over $560 million did not go to new and amended items.

[1] 2018-19 Budget Estimates. Official Committee Hansard Senate Community Affairs Legislation Committee estimates 30 May 2018. https://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/ca/2018-2019_Budget_estimates. Accessed 3/12/18

It is concerning to the AMA when the principle of cost neutrality is applied in the MBS Review recommendations. Government should appropriately fund all reviewed MBS items, without downgrading clinically appropriate practices, especially where this may cause inequities amongst particular population groups (eg rural patients).

Accordingly, the AMA notes USANZ disagreement with the need for a 20% reduction in the rebate for transrectal ultrasound (TRUS) guided biopsy of the prostate (which offsets a proposed 20% increase in an updated transperineal descriptor) for prostate biopsy due to its impact on certain patient groups (Item no. 37219 listed on pages 45-49 of the report).

The AMA urges the MBS Review Taskforce to consider USANZ's position, that uninsured and regional/remote patients with limited access to facilities that support transperineal biopsy, will be the group most disadvantaged by this recommendation. These patient groups have the right to choose a lower cost and geographically accessible option. USANZ has advised that transrectal biopsy can also be performed on an outpatient basis (unlike transperineal biopsy) and that there is a different complication rate with regard to sepsis.

Furthermore, according to information provided by USANZ, transrectal prostate biopsy is the most common and widely accepted method of prostate biopsy worldwide and remains a valid and mainstream technique. By reducing the rebate for this item, the Government is risking the potential for an increased out of pocket expense, which will impact rural and regional areas disproportionately.

The AMA does not understand how the Government, having already garnished $600 million dollars of savings (according to published Senate estimates figures) from the MBS review, is only able to fund a more complex procedure at the expense of a clinically appropriate and more widely available procedure.

The Government has on many occasions stated that the review of the MBS is not being driven by a search for savings, that the primary purpose of the review, was to modernise the MBS and make sure the services listed on it were best practice. The AMA had given its support to the review on the grounds that its main focus was on eliminating inefficiencies and reflecting advances in medical practice.

The AMA urges the MBS Taskforce and Government to work with USANZ and other relevant stakeholders to come to mutually agreeable changes to the urology items in the MBS that align with contemporary clinical evidence and practice and improve health outcomes for patients.

Yours sincerely

Tony Bartone
President