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Professor Bruce Robinson
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Dear Professor Robinson

RE: Medicare Benefits Schedule (MBS) Review – Gynaecology, Nuclear Medicine, Breast Imaging clinical committee reports

I am writing to provide feedback on the reports from the gynaecology, nuclear medicine and breast imaging MBS Review clinical committees that were received in August as part of the MBS Review Taskforce's targeted consultation. At the end of this letter I also provide further observations regarding the MBS Review in response to your letter to Dr Michael Gannon dated 24 May 2018.

The AMA has always stated its support for a review of the MBS, provided it is clinician-led with a strong focus on supporting quality patient care. This includes having the right mix of practising clinicians on each committee, with genuine input into a process of transparent decision making. We wish to ensure that the review process will deliver a schedule that reflects modern medical practice by identifying outdated items and replacing them with new items that describe the medical services that are provided today. In doing so, it is crucial that any savings from the MBS review be reinvested into the MBS, and that the review is not simply a savings exercise.

In the first instance, the AMA generally refers to the relevant colleges, associations and societies (CAS) for their clinical expertise and advice on the report findings and recommendations at this level of detail. I therefore note with great interest, the important feedback, from the Royal Australian and New Zealand College of Radiologists (RANZCR), the National Association of Specialist Obstetricians and Gynaecologists (NASOG) and the Australian Diagnostic Imaging Association (ADIA) on the relevant recommendations of the three clinical committee reports aforementioned.

Accordingly, I write to make you aware of the broader strategic and policy aspects that have been commonly raised by the CAS groups in relation to the above mentioned clinical committee reports. Whilst the AMA provides some response to specific item changes (see below), we are not in a position to comprehensively cover off on all the clinical recommendations. Therefore, the AMA urges the MBS Review Taskforce and clinical committees to consider the specific clinical feedback the CAS groups provide on the review recommendations, as they are best placed to respond in detail and provide clinical evidence and best practice options. This feedback appears to be well thought out and considered and deserves to be considered and discussed within the MBS Review.

1. Report from the Gynaecology Clinical Committee

Inadequate profession engagement

I note and commend the MBS Review Taskforce on the representation from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) on the Gynaecology Clinical Committee. However, concerns have been raised with the AMA regarding inadequate profession engagement and uncertainty in the robustness of the recommendations— due to exclusion of the specialist societies such as NASOG in the review process; limited surgical experience representation on the committee providing clinical advice that is not reflective of the full spectrum of on the ground clinical experience, and lack of evidence to support the report recommendations. The AMA urges the MBS Taskforce and its Gynaecology Clinical Committee to closely consider feedback received from NASOG and other relevant societies and associations who will add the breadth and depth of current clinical practice perspective to the review and its recommendations.

The AMA is in support of a number of the craft groups (eg NASOG, Australian Gynaecologic Endoscopy and Surgery Society) and individual clinician's objections to the proposed changes with respect to introduction of time-based item numbers; changes that increase complexity of item structures and descriptors; and increased administrative requirements such as photographic and histological evidence. These are discussed further below.

Time based item descriptors – perverse incentive and unintended consequences

Traditionally surgical operations are rebated to patients based on the complexity of the procedure and the content of the operation. Inclusion of minimum procedural times in item descriptors introduces perverse incentives and could lead to unintended consequences. I'm advised by the obstetric and gynaecology profession that evidence on procedural times and training supports the fact that highly trained surgeons (i.e. minimally invasive fellowship trained and subspecialists) perform more complex procedures in a shorter operative time and with fewer complications. Furthermore, the profession notes that natural variation in surgical times for procedures can be influenced by factors such as surgeon training and experience, theatre team experience, anaesthetist, assistant, patient factors, and equipment availability.

Incentivising prolongation of surgical time should therefore not be encouraged in surgical professions, due to the great natural variation between surgeons' practice and the clear correlation between increased operating times and poorer surgical outcomes. The proposal to positively correlate MBS rebates with operating times may do more harm than good. Moreover, the clinical committee report does not quote any data or studies of optimal surgical times for particular operations to support mandating minimum surgical times.

Additional auditing provisions – onerous and unnecessary

The AMA supports the craft groups objections to the recommendations that add further administrative burden on doctors simply for Medicare auditing purposes and not for clinical objectives. Whilst photographic and histological evidence are a desirable adjunct, particularly in explaining the surgery to patients and for surgical records they should not be mandatory due to the impracticality of adhering to the restriction in real world surgery

That is, the recommendations may disadvantage doctors in smaller or regional hospitals where access to photographic equipment may either be more limited or more susceptible to maintenance delays. The AMA is also advised that doctors working in large institutions can also have problems with photographic equipment and alternative replacements may not be available given the demand on laparoscopic equipment in the theatre complex.

Furthermore, the AMA is not aware of evidence or history to suggest gynaecologists have been inappropriately claiming item numbers to demand this extra level of auditing evidence. If the clinical committee would like to retain the reference to photographic and histological evidence in the item descriptor, perhaps the following wording could be considered - *"appropriate documentation of disease; ideally with clinical photography or histology".*

Item restructure – simplification and streamlining are required

The AMA notes that existing MBS items 35638 is recommended to be split into three items and the highest volume services are proposed to have a fee reduction whilst the rarest operations will attract a 10 per cent fee increase. Due to the volume of operations going in to the lower rebated number this is likely to result in a significant drop in gynaecological surgical rebates. The AMA calls on the MBS Taskforce to consider a streamlined MBS item structure that is simple for the profession to use which increases the prospect for improved compliance, as opposed to a detailed but complex and difficult to implement schedule.

The AMA reiterates again that the review should not simply be a savings exercise and that any savings from the MBS review be reinvested into the MBS – and not just in indexation, which is the regular role of responsible government.

Recommendation 19, Item Number 35750

The gynaecology clinical report recommends splitting item 35750 – *laparoscopically assisted hysterectomy* into two items, to differentiate and favour total laparocopic hysterectomy (TLH) via a higher rebate, over laparoscopic assisted vaginal hysterectomy (LAVH).

The AMA does not agree that TLH should be rebated at higher levels than LAVH. The AMA is advised there may be time differences between LAVH and TLH, but there is no evidence to suggest that the generally longer time to perform a TLH than a LAVH provides any health benefit to patients or reflect modern practice. NASOG also advises that the decision to perform a TLH or LAVH depends on the skills of the particular surgeon, patient characteristics, surgical training and regional variation in hospital facilities and equipment. Further clinical advice received regarding this recommendation, is that vaginal surgery is the safest approach and that TLH carries a higher rate of ureteric injuries even when learning curve and experience is accounted.

The AMA is concerned the proposed higher rebate may encourage more TLH and believes that individual choice of procedure should be made by the doctor in the best interest of their patient, without the influence of higher rebates to patients that is ungrounded on clinical evidence.

Based upon clinical advice received, the AMA also does not support the inclusion of "with or without removal of the tubes as a risk reducing surgery or ovarian cystectomy or removal of the ovaries and tubes due to other pathology" in the descriptor for item 35750 in relation to LAVH or TLH. These procedures should remain in the descriptor for item 35753, as the profession has indicated to the AMA that "removal of the fallopian tubes or oophorectomy at hysterectomy is not always 'simple' to perform, does require significant laparoscopic skill, and has evidence confirming potential benefit. And significant preoperative counselling is required in relation to management of the fallopian tubes/ovaries at hysterectomy".

2. Report from the Diagnostic Imaging Clinical Committee – Breast Imaging

Consultation with sector to determine MBS item fees

The AMA supports the Australian Diagnostic Imaging Association's (ADIA) call for the sector to be consulted as further economic modelling is undertaken to determine a fee for the new item for an ultrasound guided breast biopsy proposed in recommendation 1 of the clinical committee report.

MRI for evaluation and treatment planning of breast cancer

The AMA further notes ADIA's commentary on the MBS Review's missed opportunity to recommend Medicare-listing of Magnetic Resonance Imaging (MRI) for evaluation and treatment planning of breast cancer, when there is a discrepancy between clinical examination findings and conventional imaging findings. The AMA is advised that it is "standard of care" for 10 to 15 per cent of patients diagnosed with breast cancer, and that MSAC did not support listing the service in 2015[1], because it did not consider the latest evidence. I understand that a subsequent application has been in the MSAC system since early 2016[2], and during this period, patients are being forced to pay $600 or more in private fees.

The AMA supports the Breast Cancer Network of Australia (BCNA), Breast Surgeons of Australia and New Zealand, RANZCR and ADIA positions to advocate for Medicare listing of this service, as demonstrated by the following video to mark International Day of Radiology in 2015: https://www.youtube.com/watch?v=x2nX6McwSQY.

Multiple services rule

The AMA notes and commends the Diagnostic Imaging Clinical Committee's final report *recommendation 31 - That the multiple services rules for diagnostic imaging services be simplified and streamlined,* in response to RANZCR's 2017 Multiple Services Rules Summary Paper. I understand that the issue regarding existing multiple services rules was referred to the PRC for additional consideration (page 133 of DICC final report).

The AMA requests that breast imaging MBS items be considered, along with other relevant items, to determine what impacts, if any, the multiple services rule has on the delivery of these services to patients. The AMA is advised that this is particularly an issue for breast imaging patients who often require a biopsy following a diagnostic test where breast cancer is suspected.

3. Report from the Diagnostic Imaging Clinical Committee (DICC) – Nuclear Medicine

The AMA understands that the DICC has worked closely with relevant CAS groups (eg RANZCR, ADIA and the Australasian Association of Nuclear Medicine Specialists-AANMS) in reviewing the nuclear medicine MBS items and that these specialty groups are generally supportive of the report recommendations. I highly commend the clinical committee's collaborative work with the profession in this area.

On a separate note, RANZCR has advised AMA that it does not support the restrictions recommended by the Cardiac Services Clinical Committee to referrals for myocardiac perfusions studies (MPS), recommendations 5.1 and 5.2 of that report.

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[1] MSAC application 1333 – Breast Magnetic Resonance Imaging http://www.msac.gov.au/internet/msac/publishing.nsf/Content/1333-public. Accessed 18 October 2018.

[2] MSAC application 1464 – Breast Magnetic Resonance Imaging for improved definition of the breast cancer primary http://www.msac.gov.au/internet/msac/publishing.nsf/Content/1464-public. Accessed 18 October 2018.

RANZCR advises that there are a range of clinical circumstances where MPS is superior to stress echo and the decision on which test to refer should remain the clinical judgement of the referrer rather than a long list of restrictive indicators being included in the Medicare item descriptor.

The AMA stands by its continuing support for item descriptors that are not overly restrictive, which allow appropriate clinical judgement for each individual patient. To that end, the AMA urges the MBS Review Taskforce to consider the specific clinical feedback from the specialty groups on item descriptor restrictions.

4. Broader MBS Review observations

Operation of committees

A number of AMA members who are on the MBS Review clinical committees have expressed concern about the available expertise and balance of membership on the committees. The AMA has been advised that some committees are being asked to provide recommendations on schedule items which they do not have specialist qualifications to address.

Committees must also have a balance of public and privately practising clinicians; otherwise recommendations are made without a full understanding of the potential impact on all sectors. In your letter to me, you stated that you are working with colleges and societies to discuss potential chairs of committees – it is surprising then that we still have issues being raised regarding the wider composition of committees.

In regard to MBS Taskforce and clinical committee recommendations, I seek assurance that proposed changes to one area of the MBS is considered within the context of the whole service, such as the interrelationship between general practitioner, pathology and diagnostic imaging services. This is particularly important in the targeted consultation approach where it is not clear to the AMA who is being consulted, and on what, and the report is not publicly available.

But equally, I understand that multiple committees have considered the same, or similar parts of the schedule, at various points in time. There must be a mechanism that puts any suggested changes back through the clinical committee who has primary responsibility for that part of the schedule.

I would therefore seek reassurance that all recommendations relating to a particular medical specialty, are always approved by the MBS clinical review committee responsible for that part of the schedule.

Communication and consultation

Whilst I understand the rationale for targeted consultation there are associated risks. This includes relevant stakeholders being missed (as occurred with the Royal Australasian College of Surgeons during the oncology review); and the process becoming increasingly opaque for the wider medical profession, resulting in mistrust and reduced confidence in outcomes of the MBS Review. It is for this reason the AMA has asked that the reports continue to be hosted on the Department's website.

I note that the Taskforce was producing quarterly newsletters up until June 2017. I call on the committees and Taskforce to re-instate early, regular and appropriately detailed updates to the broader medical profession (eg via direct letters, Department website) regarding the high-level issues identified by committees, timing of targeted consultations and which stakeholders are being targeted for consultation.

This would significantly increase transparency in the review process and allow individuals and organisations of the medical profession the opportunity to actively engage (particularly if they have not been directly targeted); and reduce the risk of inaccurate recommendations downstream. Furthermore, as the AMA has raised, the reports should be publicly available, and if the reports are being sent via a targeted manner, that all recipients know who has received a copy. Considering this process is reviewing publicly funded Medicare services, the reports on potential changes on the system should also be public.

Conclusion

The shortened review timeframe presents risks for the clinical appropriateness of proposed changes and increases potential for unintended consequences. I urge you to consider the measures I propose in this letter to mitigate these risks.

Separately to the above issues, we have discussed previously that the review is not a savings exercise, but I note that Senate estimate transcripts from earlier in the year indicated $600m in government savings from MBS review, with only $40m reinvested into new items. I seek your reassurance that the review, particularly under the accelerated process, is not simply a savings exercise for government. I also seek your assurance that there is consideration of how revised items and schedule restructures impact the overall stability of each specialty. This is particularly important in areas such as pathology and diagnostic imaging where there is high service volume with low margins. Noting the government's strong focus on putting downward pressure on out-of-pocket costs for patients, it is critical the MBS review does not inadvertently undermine this policy intent.

Finally, I would like to invite you to present at the next Colleges, Associations and Societies conference hosted by the AMA. Members greatly valued the information you provided on the MBS Review at the last conference held in March 2017. My office will be in contact with your office to follow up on this invitation, with a view to holding a meeting as soon as practical.

Yours sincerely

Dr Tony Bartone
President