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AMA submission to Medicare Benefits Schedule Review Taskforce consultation paper

The AMA has always supported review of the Medicare Benefits Schedule (MBS).

From 1990 until 2009, with the agreement of successive Health Ministers, the AMA convened the Medical Benefits Consultative Committee (MBCC) to undertake evidence-based reviews of services on the General Medical Services Table (GMST) of the MBS to ensure the MBS reflected and encouraged appropriate clinical practice[1]. Members of the MBCC were representatives of the Department of Health and Ageing, the Health Insurance Commission, the AMA and relevant craft groups of the medical profession.

The Relative Value Study reviewed the services and fees in the GMST. It was jointly designed by the AMA and the Department of Health and Ageing, and conducted under the auspices of the Medicare Schedule Review Board which was made up of representatives of the AMA and the Department. It commenced in 1994 with a joint discussion paper and finished in 2000 with a final report – unfortunately with no result for patients, the medical profession or the Government.

After the MBCC process was abandoned by Minister Roxon[2], the AMA continued to be actively involved in the shaping of new processes to review the MBS (see Attachment A).

In December 2009, in response to the 2009-10 Federal Budget measure to develop a quality framework for reviewing Medicare services, in a letter to Minister Roxon, Dr Andrew Pesce, AMA President stated:

> *"The AMA agrees, in principle, that there needs to be a robust, evidence-based and transparent process for considering the content of the Medicare Benefits Schedule".*

The AMA's overarching concerns with the process proposed at that time was two-fold:

1. It would be a resource intensive exercise for the medical profession; and
2. While recognising that government will always reserve the right to make final decisions – transparency of process, decisions of government, and the reasons for decisions that are inconsistent with the outcomes of the assessment and review process that the medical profession participated in, was essential.

The same is equally true today for this MBS Review.

[1] Department of Health and Ageing and Australian Medical Association. *Guidelines for Preparation of Submissions to the Medicare Benefits Consultative Committee*. https://ama.com.au/submission/guidelines-preparation-submissions-medicare-benefits-consultative-committee-mbcc.
[2] Minister for Health and Ageing from 3 December 2007 to 14 December 2012.

The medical profession is being asked to commit significant time and effort to a large, but rapid, review of the MBS with little certainty that the final outcomes will support the holistic needs of patients.

It is critical that this current review process is not prejudiced or compromised from the start by the comments made by the Minister for Health and the Chair of the MBS Review Taskforce that:

- 97 per cent of MBS items have never undergone consideration to determine whether or not they are actually clinically-effective, cost-efficient or safe[3]; and
- 30 per cent or more of health expenditure is wasted on services, tests and procedures that provide no or negligible clinical benefit and in some cases might be unsafe and could actually cause harm to patients[4].

Firstly, as described above, there have indeed been processes for reviewing the evidence base for services on the MBS, which were no less rigorous than what is now proposed for this Review. Further, from a clinical perspective not every medical service described in an MBS item warrants a review of the evidence – it is internationally accepted best practice that general anaesthesia be administered prior to surgery, and that malignant brain tumours be removed.

Secondly, no single academic study has unequivocally identified services that are wasteful or harmful. They act only as pointers to services that should be reviewed so that we can better understand the clinical contexts in which their use are likely to represent low-value care as discussed by Elshaug et al in *Over 150 potentially low-value health care practices: an Australian study* (MJA 197(10) 19 November 2012).

Finally, there is no evidence base to characterising 30 per cent of health care in Australia as unnecessary and harmful. There are very big differences between Australian and American health care practices and the estimated 30 per cent of waste in the US[5] [6] relates not only to inappropriate medical care, but also to individual behaviours that lead to health problems and to regulatory and administrative costs. The estimate therefore cannot be applied to the Australian health system.

The Government does not need to justify the Review on such spurious grounds. A review of the MBS has the support of the medical profession because the MBS is in desperate need of updating. Let's do the review and see what the evidence does and doesn't support, without any preconceptions about the number of items that should be included on (or removed from) the MBS or the quantum of potential savings.

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[3] The Hon Sussan Ley MP Minister for Health. *Four Corners a sobering insight into why Medicare Review necessary*. Opinion Piece. 30 Sept 2015. http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley116.htm?OpenDocument&yr=2015&mth=09 (accessed 30 September 2015)

[4] The Hon Sussan Ley MP Minister for Health. *Unnecessary, out-dated or unsafe medical services? Tell us about it!*. Media Release. http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2014-ley116.htm?OpenDocument&yr=2015&mth=09 (accessed 27 September 2015)

[5] PricewaterhouseCoopers' Health Research Institute. The price of excess: Identifying waste in healthcare spending. Undated. http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.html (accessed Sep 2015).

[6] New England Healthcare Institute. Waste and Inefficiency in the U.S. Health Care System Clinical Care: A Comprehensive Analysis in Support of System-wide Improvements. February 2008. http://www.nehi.net/writable/publication_files/file/waste_clinical_care_report_final.pdf (accessed Sep 2015).

A review that leads to arbitrary cost-cutting, or diverts any savings from services to the budget bottom line, will not be supported.

A sustainable health system requires:

- a thoughtful strategic approach that balances the community's expectation of what it wants from its health care system with initiatives that encourage high value choices for individuals and their treating doctor;
- recognition that what may be a low value choice for one person may be the best option for another, and thus high value for that person;
- a MBS that supports holistic care of the patient; and
- a MBS that supports preventative care, prioritises quality of life and promotes longevity.

For the support of the medical profession to continue for the duration of the Review, the profession and the individuals making the commitment to participate in the Review must have full confidence that:

- the emphasis of this Review is on patient care;
- 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; and
- the modern MBS will support:
  - patient choices, informed by their doctor's application of the best available evidence to their individual clinical and social circumstances; and
  - quality clinical care.

This will only occur if the Review process is robust and transparent and implementation is rapid so that the MBS is truly "modern" when the Review is finished.

The Review process

The consultation paper does not sufficiently describe the full process from convening experts for working groups through to implementation of changes to the MBS.

While the intention may have been to allow some flexibility, it leaves scope for unnecessary and/or unacceptable process changes to be made. A new dimension that has apparently already been added to the review process is that "new items to support care that is already part of established medical practice … would undergo … "rapid review" by the Medical Services Advisory Committee"[7].

Apart from being at odds with what is described under section 10.4 of the consultation paper, this latest development is inefficient as the clinical committees and working groups will review the available evidence that will support the need for new items for existing services. It is not clear what will be gained by another review of the same material by the Medical Services Advisory Committee (MSAC). The risk is that a different set of clinical questions will be applied that will arrive at different findings to those of the clinical committees and working groups.

[7] Prof Bruce Robinson quoted by Paul Smith *MBS review to 'recommend' new items* Australian Doctor. 6 October 2015.

The consultation paper proposes a process that will lead to a fragmented MBS because:

- items will be removed and minor amendments will be made, while new items to reflect modern practice languish in the MSAC pipeline without being added;
- there will be a bottleneck in the decision-making phase – i.e. the collation of the recommendations for, and the Minister's consideration of, changes to the MBS; and
- implementation is not part of the Review process – implementation decisions will be made by the Department either without clinical input or input from clinicians who were not part of the Review.

Cumulatively, this will undermine the value of the Review.

This Review presents a unique opportunity to quickly bring the MBS up to date. Clinicians have agreed to participate in clinical committees and working groups. The review process must capitalise on the fact that the relevant expertise will be available, and should be used to set the right clinical questions, review the clinical evidence and other relevant information, and be directly involved in implementation of amendments to the schedule.

The Review process should comprise:

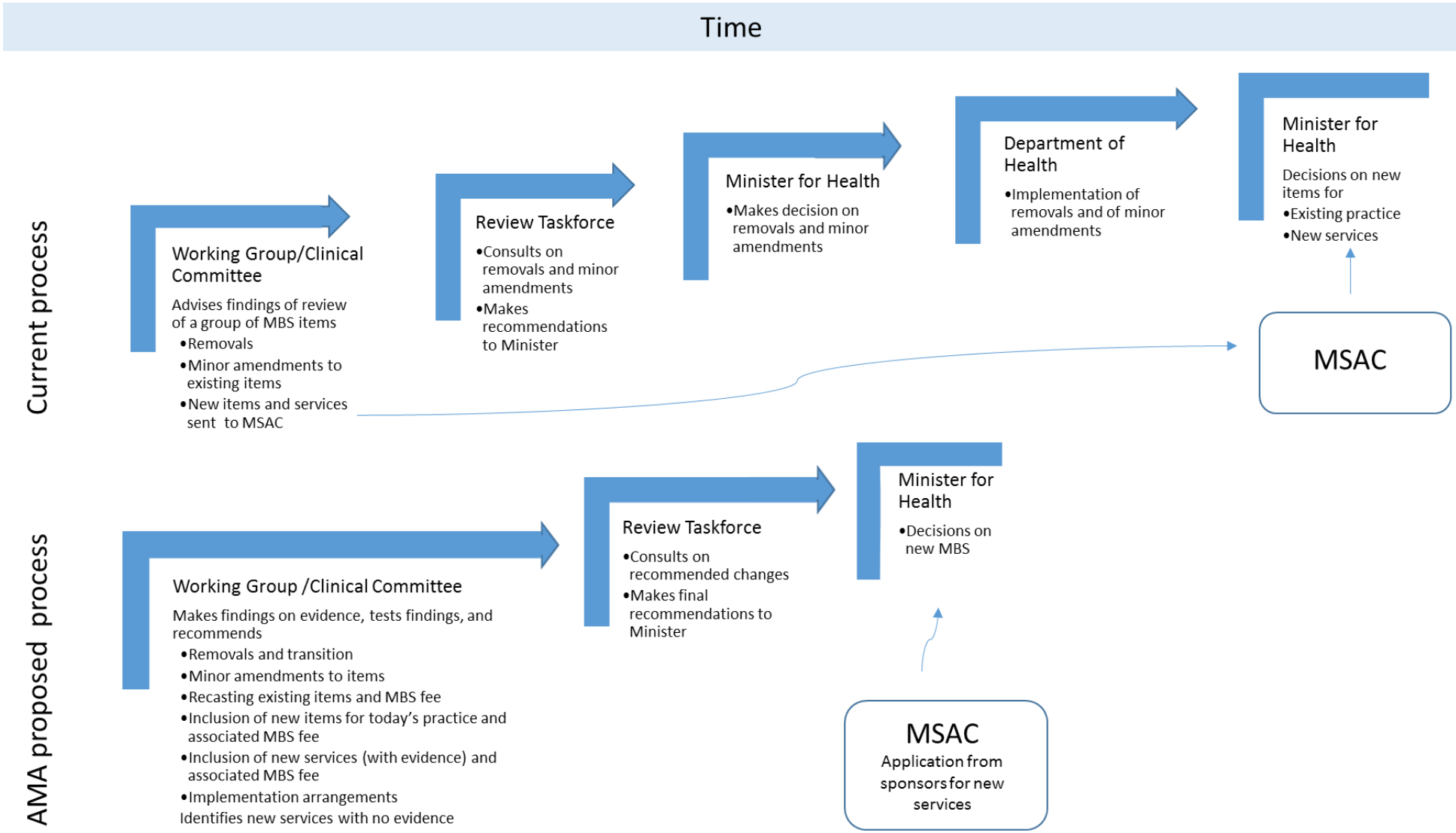
- **Clinical committees/working groups** set the clinical questions, review the available evidence, test their findings with the affected craft groups, and based on their findings recommend:
  - items to be removed and transition arrangements;
  - minor amendments to existing items;
  - recasting of existing items to reflect current practice and their fees;
  - new items for existing services to cover current practice and their fees;
  - new items for new services (supported by the evidence) and their fees;
  - implementation arrangements, including policy considerations;
- **MBS Review Taskforce** consults on the clinical committee recommendations and makes recommendations to the Minister for MBS changes;
- **Minister for Health** decides on the new MBS;
- **Department of Health** writes drafting instructions to implement changes in regulations; and
- **Medical Services Advisory Committee** continues to receive applications from sponsors for new services not captured by the clinical committee review i.e. those that are not part of routine practice today (and which may have been identified by the clinical committee as having no evidence).

While this process would require that the clinical committee/working group remit is broader than currently proposed and would therefore take longer, it will allow the entire group of services to be updated simultaneously and completely as they operate collectively within the MBS. This part of the review process will be guided and informed by the Department on all of the pertinent issues.

The decision making and implementation phases would be expedited and bottlenecks minimised as a result of working groups/clinical committees progressing at slightly different rates and with differing magnitudes of work.

This proposed option allows for consideration of the impacts of the recommendations from the clinical committees and working groups in their entirety to ensure they effectively support a holistic approach to patient care.

A representation of the AMA process compared to the Government process (as we understand it) is:


Time
Current process
Working Group/Clinical Committee
Advises findings of review of a group of MBS items
•Removals
•Minor amendments to existing items
•New items and services sent to MSAC
Review Taskforce
•Consults on removals and minor amendments
•Makes recommendations to Minister
Minister for Health
•Makes decision on removals and minor amendments
Department of Health
•Implementation of removals and of minor amendments
Minister for Health
Decisions on new items for
•Existing practice
•New services
MSAC
AMA proposed process
Working Group /Clinical Committee
Makes findings on evidence, tests findings, and recommends
•Removals and transition
•Minor amendments to items
•Recasting existing items and MBS fee
•Inclusion of new items for today's practice and associated MBS fee
•Inclusion of new services (with evidence) and associated MBS fee
•Implementation arrangements
Identifies new services with no evidence
Review Taskforce
•Consults on recommended changes
•Makes final recommendations to Minister
Minister for Health
•Decisions on new MBS
MSAC
Application from sponsors for new services

There is an expectation within the medical profession, founded on goodwill, that this Review will deliver a modern MBS. Having said that, there is a long history of governments purporting to take action on the MBS and not delivering any real results – the Relative Value Study remains very much in the minds of the clinicians that were involved, and those that had high expectations of its outcomes. This Review has great appeal and promise for practitioners because the MBS has been left in the wilderness for far too long. It will deliver, but only if it is properly constructed. As much as the AMA understands the Government's desire not to leave MSAC out of the equation, this unique opportunity requires a unique process to arrive at a complete result. Getting only half the job done will not be acceptable.

If the Review process is to inform the proposed establishment of a mechanism for ongoing review of MBS items to ensure the MBS remains up-to-date, new approaches, such as the AMA proposed process, will need to be considered. Otherwise the current unsatisfactory arrangements will continue, and the MBS will not be properly managed into the future.

Themes in the consultation paper

There is an overarching theme in the consultation paper that the MBS, and its fee for service approach, is THE driver of too much, or inappropriate care, and therefore the MBS should be THE vehicle to address that. As a result, the paper offers a range of suppositions and implies that these will be tested and resolved by the Review.

Sustainability of the health system is critically important – to patients, to payers and to doctors. But the MBS, and the MBS Review, are not the vehicles by which to address sustainability.

The health economics and policy issues that have to be considered when looking at sustainability, cannot be considered by 35 clinical committees (the reviews will be a significant enough task). These broader issues are especially difficult to analyse in the absence of an overarching strategic direction for health care in Australia, and in the context of a polemical Government rhetoric regarding a "spending problem". The consultation paper does not identify when the consolidated financial and economic impacts of removing or amending MBS items will be considered.

The MBS represents 12.5% of total health expenditure, and 30% of the total Commonwealth expenditure on health[8]. Therefore, even if the MBS were to define appropriate use (or spending) and in so doing restrict the payment of a benefit to the patient, it may only have the effect of reducing the Medicare outlay and shifting the cost elsewhere.

There is no certainty that the Review outcomes for clinical care delivered via the MBS will be mirrored in the public system. Patients will seek the clinically appropriate treatment for them in the public sector if it is not available to them in the private sector.

The balance between the private and public system cannot be overlooked by this Review. The public system relies on a strong and innovative private health system. If the private system has limitations imposed by a MBS that constrains holistic medical care, this will place additional pressure on public hospitals already struggling to meet ever growing demand. In addition, the private sector is also a training ground for Australia's next generation of doctors. Limitations

[8] Australian Institute of Health and Welfare. *Health expenditure Australia 2013-14*. Table A6. Unreferred medical services $7,837m. Referred medical services $11,593m.

imposed on private practice by the MBS will limit the quality of the training experience in the private sector.

The way to tackle sustainability is not through measures that limit the ability for patients to receive appropriate treatment for their individual clinical and social circumstances, but through clinical stewardship.

Stewardship refers to avoiding or eliminating wasteful expenditure in health care. It does not involve rationing of limited resources. Stewardship aims to maximise quality of care and protect patients from harm while ensuring affordable care in the future.

Stewardship is an ethic that embodies the responsible planning and management of resources. For the profession of medicine, stewardship is both a value and a guide to behaviour. The AMA Code of Ethics instructs doctors to use their special knowledge and skills to minimise wastage of resources, while remembering their primary duty is to provide their patient with the best available care.

There are many initiatives to foster clinical stewardship. Some are newly introduced, such as the Choosing Wisely program. Others have been in the pipeline for some time, with their true usefulness for patient care yet to be fully understood, such as the atlas of variation.

For reasons yet unknown, but potentially as a result of many initiatives, growth in health expenditure is slowing. Medicare expenditure increased by 5.6% in 2014-15. Over the last seven years this is the second lowest annual increase in Medicare expenditure. Last year (2013-14) was the lowest at 3%. The Government's Commission of Audit report stated that Medicare expenditure was expected to grow by 7.1% per year until 2023-24 and continue growing. Yet the last two years have been well under that projection.

Australia has achieved two years of modest, sustainable growth with 3.1% growth in 2013-14 following 1.1% growth in 2012-13 (a year with the lowest growth rate in health expenditure since the Government began reporting it in the mid-1980s). This is now two years in a row where health expenditure has been below projections and below the long term average annual growth in health expenditure (5% over the last decade).

A philosophy to change payment arrangements without a solid foundation and specific reasons for so doing e.g. bundling benefits for assistance or anaesthesia at surgery, or restricting care to match (untested) data from a different geographical area, will be at the expense of patient care.

The Review process is not sufficiently structured or resourced to enable proper consideration and to establish evidence based reasons for making wholesale changes to the health care system via the component that is the MBS. In this regard, the proposed review is attempting to achieve a scope of review and action beyond what is feasible and credible.

October 2015

Attachment A

Chronology of AMA contributions to MBS arrangements

2009-10 Quality Framework for Reviewing Services – new evidence-based framework for reviewing existing services.

25 November 2009	Preliminary discussion with the Department of Health and Ageing on the draft consultation paper on the development of a Quality Framework for the MBS
22 December 2009	Preliminary submission to the Department on the initial MBS Quality Framework Applications and Guidelines
11 January 2010	Submission to the Department on the MBS Quality Framework Applications and Guidelines
27 January 2010	Submission to the Department on the revised MBS Quality Framework
29 June 2010	Submission to the Medical Benefits Review Task Group on the MBS Quality Framework discussion paper
16 December 2010	Submissions to the Department on the proposed processes for reviewing existing MBS items

2011-12 MBS Enhanced Management Framework – expand MSAC to conduct rolling reviews of quality, safety and fee levels of existing items "considering the clinical quality and appropriateness of MBS items and fees".

17 February 2011	Submission to the Department on the Changes to the MSAC Processes for Applications for Public Funding discussion paper
11 January 2012	Issues Paper submitted to the Department on managing the MBS
18 April 2012	Participated in the Medical Services Advisory Committee (MSAC) Roundtable on MSAC assessment process and MBS management

2013-14 MBS Comprehensive Management Framework – to review quality, safety and cost effectiveness of existing items.

December 2012 to March 2014	Participated in the MBS Safety, Quality and Sustainability Forums convened by the Department
2013 to 2015	Participated in 18 MSAC Reviews of existing MBS services
24 July 2013	Submission to the Department outlining the shortcomings of the Review Working Groups process and Decision Analytical Protocols to date
14 November 2013	Submission to the Department proposing a process to improve the scoping of reviews of existing MBS items

Health Technology Assessment Reviews

28 May 2009	Submission on the Health Technology Assessment Review
2 November 2009	Submission on Health Technology Assessment in Australia discussion papers