Ref: 17/66

2 November 2018

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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 – Anaesthesia clinical committee report and the maximum three item rule.

As you know, a significant number of MBS Review Taskforce clinical committee reports have been recently released to targeted stakeholders, including the AMA. Whilst the AMA and the wider profession are eager to be engaged in the MBS Review process, the release of multiple reports within shortened timeframes (around 40 per cent of the schedule) does not provide adequate time to assess the clinical appropriateness of the proposed changes, and this increases the potential for unintended consequences not being flagged.

I note that whilst the MBS Taskforce has deliberated on recommendations over the last several years, the profession has been given only weeks or months to respond. The AMA has heard of significant dissatisfaction amongst the craft groups regarding the unreasonable timeframes. The AMA therefore, urges the Taskforce to be flexible on the consultation timelines, as is reasonably practical, to ensure proposed changes are based on robust clinical and profession feedback.

Separately to this, we call on the MBS Review Taskforce to make all the clinical committee reports publicly available on the internet as they are released. This will ensure transparency of the review process, that relevant craft groups are not unintentionally missed, and that multiple clinical committees with overlapping issues and specialties can be cross referenced for accuracy and consistency.

Further to these broader issues, I also write to firstly respond to your letter dated 5 October 2018, requesting AMA's feedback on the MBS Review Taskforce report from the Anaesthesia Clinical Committee (ACC).

I would also like to also raise a significant concern regarding the MBS Review and a recommendation made by the MBS Review Taskforce Principles and Rules Committee (PRC) in its first report (2016) regarding the three-item rule for Group T8 surgical items.

These two matters are discussed below.

<u>Report from the Anaesthesia clinical committee</u>

The AMA works collaboratively with the Colleges, Associations and Societies (CAS) in responding to the MBS Reviews. The AMA believes that any recommendations that introduce limitations that jeopardise patient safety or access to care, undermine overall clinical opinion or have restrictions that run counter to evidence-based best practice, should be opposed.

With that in mind, the AMA is aware that the Australian Society of Anaesthetists (ASA) agrees with less than a third of the 67 ACC recommendations and that it has significant concerns with key aspects of the majority of the ACC's recommendations.

This is deeply concerning.

In 2017, AMA worked extensively with the Department of Health to facilitate the Australian Society of Anaesthetists (ASA) meeting with Government, and the ACC, to advise their concerns with the report. The AMA has been made aware that in early 2018, the ASA met with the Department, the Health Minister the Hon Greg Hunt MP and the Australian and New Zealand College of Anaethetists (ANZCA).

I strongly encourage the ASA concerns, and proposed responses, be considered by the ACC. It is a clear sign of the medical professions commitment to the health system that they have taken the significant time and effort to produce such considered response and they should be commended for this work.

Separately, the AMA is aware of the continuing concerns around the appointment process of panel members – you would be aware this is an issue we have raised previously on a number of occasions. I understand from the profession that such concerns continue to exist, including the lack of communication and reply to the suggested (and ultimately unsuccessful) nominations.

Furthermore, I understand the Department is working to improve the consultation process going forward, however I feel it important to point out that I am aware there was limited consultation with the ASA, ANZCA or any other group – something that would have been beneficial and potentially saved time, and money. I note the report states that *"Extensive discussions has already occurred with stakeholders including the Australian Society of Anaesthetists (ASA), the Australian and New Zealand College of Anaesthetists and the Australian Medical Association through their ASA representative"*. The advice from the ASA and ANZCA is that there has indeed been engagement with the Department, but limited consultation and evidence of change as a result, at the ACC level. Such a statement has the potential to be inflammatory, and misleading – suggesting a level of endorsement that does not exist. A similar statement was made in the surgical assistants MBS Review letter to stakeholders, which I understand from talking to the Medical Surgical Assistants Society of Australia, they also felt was misleading.

The AMA has raised in the past, with the Department, concerns from our Anaesthetist members specifically regarding the following, which are also reflected in the ASA submission:

- Lack of an evidenced-based approach to modification of MBS item numbers;
- Inconsistencies in recommendations between Clinical Committee reports;
- Erosion of patient-centred care and the targeting of vulnerable patient groups such as elderly patients, sick people, pregnant women and people with mental health issues;
- No evidence of a collaborative approach to engagement with the speciality in generating recommendations;
- No evidence of engagement with consumers;

- No consideration of the effects these recommendations will have on consumers, particularly on out of pockets costs, maldistribution of funding, access to essential clinical services; and
- the unbalancing of private/public healthcare in Australia.

Whilst the AMA is aware of the significant discontent by the anaesthetist profession, via the ASA, it does not see value in providing specific feedback on the recommendations beyond that outlined already by the relevant craft groups. The AMA urges the MBS Taskforce and Government to work with the ASA to come to mutually agreeable changes to the anaesthesia items in the MBS that align with contemporary clinical evidence and practice and improve health outcomes for patients

MBS Review - Proposed three-item rule for Group T8 surgical items

In September 2016, the PRC released its first report which recommended restricting benefits to a maximum of three MBS items, in the context of the 'complete medical service', for T8 surgical items (with existing multiple operation rule applied) (Issue 2 in the report). Due to public consultation feedback the PRC then deferred further consideration of the recommendation for Issue 2 until more MBS Review clinical committees have developed recommendations in the context of the 'complete medical service'.

Furthermore, I understand that in March 2017, you wrote to the President of the Australian Society of Otolaryngology, Head and Neck Surgery (ASOHNS) advising of the deferral of the three-item rule from the final recommendations of the PRC. The AMA membership was therefore reassured that this rule was not likely to be pursued further for any specialty, based on feedback already received.

However, on page 19 of MBS Review Report from the Urology Clinical Committee, released in September 2018, it is stated that:

> "The Taskforce has recommended that each MBS item in the surgical section (T8) of the MBS represents a complete medical service and highlighted that it is not appropriate to claim additional items in relation to a procedure that are intrinsic to the performance of that procedure.
>
> It is proposed that for surgical procedures, this principle will be implemented through restricting claiming to a maximum of three MBS surgical items for a single procedure or episode of care."

It is therefore deeply concerning that whilst on the one hand the PRC deferred its decision regarding the three-item rule, due to consultation feedback, but on the other hand this recommendation is taken forward and applied in a specialty clinical committee report (eg urology) without regard or reference to any previous profession feedback on the recommendation.

The AMA has received compelling feedback from a large section of the profession across multiple specialties, that the three-item rule itself is not currently accepted as a fair or workable option. Furthermore, I have received information that some professions have received advice that the three-item rule across all specialties is being put to committees as a fait accompli and that it is non-negotiable.

I seek your strongest assurances that the three-item rule is open for further discussions and that the MBS Taskforce will coordinate with the affected CAS' to come to mutually agreeable changes; that is consistent, as much as is reasonable, across the specialties; that align with contemporary clinical evidence and practice and improve health outcomes for patients.

Yours sincerely

Dr Tony Bartone
President