AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

MBS Review Consumer Panel Report

AMA submission to the MBS Review Taskforce

Professor Bruce Robinson, Chair
Medical Benefits Schedule Review Taskforce
By email: mbsreviews@health.gov.au

Introduction

The Australian Medical Association (AMA) welcomes the opportunity to provide a response to the draft MBS Review Taskforce report from the Consumer Panel. The AMA has always stated its support for a review of the MBS, provided it is transparent, clinician-led, not a cost-saving exercise and has a strong focus on supporting quality patient care.

The commitment is underpinned by the shared principles of:

- **Stewardship** of the health system and a shared responsibility for its ongoing sustainability;
- **Patient access** to affordable health care;
- **Recognition** that both the public and private health systems support universal health care;
- **Support for investment** in evidence-based mental health services;
- **Support for improvements** for the health of Aboriginal and Torres Strait Islander people to close the gap in health outcomes between Indigenous and non-Indigenous Australians;
- **Transparency** of decision-making of data and information transfer, including to patients;
- **Accountability** for structural reform out to 2020-21, providing the platform for more ambitious change over the next 10 years; and
- **Commitment** to the integrity of Australia's world class health system, including patient safety and high-value clinical care.

Overarching comments

Clearly, the medical profession, the Government, the public and private health sectors and consumers are the key players to ensure the health system, underpinned by Medicare, continues to provide high value clinical care with patient safety at the forefront.

The AMA acknowledges the work of the MBS Review Taskforce, Clinical Committees, the Department and individual consumer representatives in engaging with consumers as part of the review of the 5,700 MBS items.

The AMA supports consumer engagement with the current and ongoing review of the MBS. The core values of patient-centred care are embedded in the AMA Code of Ethics[1] and the AMA was heavily involved in drafting 'Good Medical Practice: A Code of Conduct for Doctors in Australia' adopted by the Medical Board of Australia which states that *"Good medical practice is patient-centred."*

The AMA acknowledges the importance of partnering with consumers in planning, design, delivery, measurement and evaluation of systems and services as prescribed by the National Safety and Quality Health Service's *Partnering with Consumers Standard*, and applied by the MBS Review Taskforce, with support from the Consumer Health Forum (CHF) of Australia. The AMA also notes the statement that there should be "equity of access and outcome" – noting we have seen reports of areas where the new MBS restrictions have meant that some service provision (including in rural areas) has actually temporarily ceased as a result of the new items being implemented, without systems being in place to ensure services continued (ie resulting from inadequate Department of Health and Medicare communication, or Department of Health and Australian Health Practitioner Regulation Agency communication).

More recently, we've seen disagreement between Department of Health and Medicare, which has left a certain cohort of patients (3 to 4 year old children) without a particular anaesthetic item rebate functioning effectively. The AMA is often at the coal face of negative consumer impacts resulting from the MBS and we again urge the Departments to work more effectively, in a timelier manner, in a more cohesive whole of government manner, when implementing changes to the MBS.

Furthermore, we note the statement that talks about "proactively looking at scope of practice of more than one clinical group", presumably to increase service provision by different specialities of medical practitioners, but at the same time the AMA notes the increasing use of sub-specialty/ specific requirements in new MBS item descriptors.

The consultation report also talks about out of pocket costs (OOP) being considered when determining relative item costs, and total OOPs being considered when multiple services are associated with a condition being treated. The AMA has not seen this result in improved rebates for many conditions, and has on a number of occasions highlighted how some changes will impact, and increase, the OOPs consumers face – either because of the new item design, or because we have seen insurers reduce their rebates when introducing new item rebates.

Indeed, it is one of the reasons the AMA has taken it upon itself to produce it's own guide to *Informed Financial Consent*, with a strong emphasis of explaining what an MBS item is, the need to be sure of the items being used, and its fee, to assist in determining a likely OOP. The AMA has not seen the MBS review place a strong emphasise on improving the OOP situation for patients, via an improved MBS rebate investment in many parts of the schedule, nor have we yet seen this flow through to considered timely alignment with Private Health Insurance (PHI) banding procedures, which again can exacerbate patients out of pocket costs.

[1] https://ama.com.au/position-statement/code-ethics-2004-editorially-revised-2006-revised-2016

For this reason, the AMA agrees with the report that there needs to be more communication and education around the MBS changes at the implementation stage – it is clear to the AMA there is confusion around the changes, and what they mean. The AMA has seen confusion between the profession, private hospitals, software and billing agencies, private health insurance and state insurance schemes. In some instances, this has meant patients have not been able to claim rebates from insurers for weeks at a time, or be provided with an informed financial consent prior to the procedure – due to the wider "private system" not being ready in time with MBS implementation. This is detrimental to patients, and seems to be silent in the report – despite the AMA witnessing the significant inconvenience felt by patients. The AMA has written and engaged extensively on this issue, including here: https://ama.com.au/ausmed/rocky-road-ahead-health-system. Thankfully, we have seen the Department of Health change its processes in response, release information earlier and hold education sessions with stakeholders, and worked to amend this system - and while we still have a way to go to refine this process, we do recognise and thank them for this change. It is a step in the right direction.

Process vs Outcomes

The AMA's Position Statement (2013) on *Quality and Safety in Hospital Practice*[2] requirements for an effective quality and safety system recommends a "Focus on Outcomes over Process—*While there are advantages to standardisation of processes in some areas of practice, a quality system must not allow the process to become the aim. Work processes should not be changed unless there is good evidence that the change will improve outcomes in a systematic way. Change should not be self-fulfilling or symbolic."*

The AMA notes that the Consumer Engagement Resource, as outlined in the report, appears to be a useful concept to assist consumers to engage in the process of planning, design, delivery, measurement and evaluation of the MBS – however questions must be asked as to whether this should be funded by the Department, or by the Consumer organisation they are representing, noting no similar process was put in place for other clinical committee representatives.

Furthermore, the AMA suggests that the Consumer Panel should move from process to outcomes. This could be achieved by developing a tool or set of questions that critically evaluates the potential or real impact on patients of proposed or implemented MBS changes *resulting* from the MBS Review. The questions could be set around key indicators of patient access to safe and clinically effective medical services; and from the viewpoints of:

- the general population;
- vulnerable or specific population groups (eg Aboriginal and Torres Strait Islander people, children);
- geographical locations (eg regional, rural and remote);
- practicalities of the change (eg the newly implemented colonoscopy items are now very prescriptive on the clinical indications for the patient to be eligible for a MBS rebate – this could disadvantage patients where there are incomplete or unavailable medical records); and
- increased out of pocket costs for disinvested MBS services.

[2] https://ama.com.au/position-statement/quality-and-safety-hospital-practice-2013

Measurable outcomes

The AMA's submission (2016) to the *ACSQHC Consultation Regulation Impact Statement: costs and benefits of implementing the revised NSQHS Standards* noted that "standards need to be implementable with measurable outcomes."

Whilst many of the Principles recommended in the Consumer Panel report have merit, the AMA suggests that these should be applied by the MBS Review Taskforce in a meaningful way and not just be simply symbolic.

The AMA acknowledges that many MBS Review recommendations have modernised the MBS (eg spine surgery services) and invested in medical services (eg increase rebates for complex spine surgery, dialysis in rural areas), however, much of the medical profession perceive that the MBS Review is a cost saving exercise, despite the Government's reassurance. An update on government savings from the MBS Review and areas of reinvestment would be a useful indicator of the ongoing investment in safe and clinically effective medical services via Medicare.

In 2018, Senate estimate transcripts indicated $600m in government savings from MBS review, with $40m reinvested into new items. Whilst the AMA welcomes Government investment in traditionally underfunded areas such as primary care (eg $1.1b Strengthening Primary Care package announced in the 2019-20 budget) greater transparency is required about how the MBS Review savings are being spent. A clear table outlining specific source of savings and where that money has been put to better/more appropriate use would assist with transparency for patients and the medical profession.

Equally important will be monitoring the impact of disinvestment in medical services, such as anaesthesia and colonoscopy. In addition, the AMA notes that the MBS Review had the tendency to recommend and make changes to the MBS items that significantly increase the complexity of the item descriptors, seemingly for compliance and budgetary reasons, which are going to make understanding the MBS from a consumer perspective even more challenging.

For example, MBS item 11503, implemented on 1 November 2018, now reads more like a medical encyclopedia, and less like an insurance scheme listing of a safe and accepted medical service:

> Complex measurement of properties of the respiratory system, including the lungs and respiratory muscles, that is performed:
> (a) in a respiratory laboratory; and
> (b) under the supervision of a consultant respiratory physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports on tests performed; and
> (c) using any of the following tests:
>
> (i) measurement of absolute lung volumes by any method;
> (ii) measurement of carbon monoxide diffusing capacity by any method;
> (iii) measurement of airway or pulmonary resistance by any method;
> (iv) inhalation provocation testing, including pre-provocation spirometry and the construction of a dose response curve, using a recognised direct or indirect bronchoprovocation agent and post-bronchodilator spirometry;
> (v) provocation testing involving sequential measurement of lung function at baseline and after exposure to specific sensitising agents, including drugs, or occupational asthma triggers;

(vi) spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises equipped with resuscitation equipment and personnel trained in Advanced Life Support;
(vii) measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes;
(viii) simulated altitude test involving exposure to hypoxic gas mixtures and oxygen saturation at rest and/or during exercise with or without an observation of the effect of supplemental oxygen;
(ix) calculation of pulmonary or cardiac shunt by measurement of arterial oxygen partial pressure and haemoglobin concentration following the breathing of an inspired oxygen concentration of 100% for a duration of 15 minutes or greater;
(x) if the measurement is for the purpose of determining eligibility for pulmonary arterial hypertension medications subsidised under the Pharmaceutical Benefits Scheme or eligibility for the provision of portable oxygen—functional exercise test by any method (including 6 minute walk test and shuttle walk test);

each occasion at which one or more tests are performed. Not applicable to a service performed in association with a spirometry or sleep study service to which item 11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies. Not applicable to a service to which item 11507 applies

Prior to 1 November 2018, MBS item 11503 read as follows:

Measurement of the:
(a) mechanical or gas exchange function of the respiratory system; or
(b) respiratory muscle function; or
(c) ventilatory control mechanisms.
Various measurement parameters may be used including any of the following:
(a) pressures;
(b) volumes;
(c) flow;
(d) gas concentrations in inspired or expired air;
(e) alveolar gas or blood;
(f) electrical activity of muscles.
The tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital. Each occasion at which 1 or more such tests are performed, not
being a service associated with a service to which item 22018 applies.

It appears that the outcome has not taken into account the principles of the Consumer Panel and concerns of the medical profession.

Specific comments

Principle 3. Design and use of MBS Items

The AMA supports the principle of design and use of MBS items to support safe, evidence-based, high quality consumer-centred care, and that allows sufficient flexibility to tailor treatments and care to the specific needs of individual patients, which may not align directly with Guidelines, but where the variation is well considered and appropriate.

The AMA acknowledges that flexibility and clinical discretion are required when providing quality care that is tailored to the individual patient. Disease specific guidelines for example do not always account for the complexities of caring for co-morbid patients. Recommended actions or objectives for one condition could be contraindicated for another, and guidelines do date, often

quite quickly. For these reasons, the AMA maintains its position that MBS item descriptors should not refer to specific clinical guidelines.

Principle 4. Design and use of MBS Items support fair and equitable access and outcomes for all
This principle effectively supports medical generalism. Many general practitioners, particularly those who work in rural areas, often have skills in obstetrics, aneasethesia, skin cancer, general surgery etc. The AMA supports the development of a rural generalist training pathway and practitioners being trained and upskilled to provide a range of services within a community. This principle, however, should never be used to support the inappropriate expansion of the scopes of practice of non-medical practitioners, nor the provision of services by those not appropriately qualified, skilled or supervised.

Principle 8. Use of MBS data
Principle 8 of the Consumer Panel report recommended that the MBS Review ensure *"the use of MBS data is maximised for public benefit, and with appropriate governance to ensure that public benefit does not cause harm to the individual."* This principle recommends ongoing monitoring, post-market surveillance and data availability for research purposes is integrated into the use of the MBS to support evaluation and review for quality assurance.

The AMA supports this principle to the extent that MBS data should be used where appropriate and with caution, noting the purpose of the MBS as an insurance scheme and consequently its data limitations.

The AMA's Position Statement (2013) on Quality and Safety in Hospital Practice noted that the data collected to inform quality practice must be both robust and clinically relevant. Clinicians should be consulted in the method of data collection and indicators measured. Data must be easily accessible, delivered in a logical format, and up-to-date. Clinicians should not bear an unreasonable burden of data collection or data entry. All clinicians need adequate access to appropriate information technology.

To that end, the AMA notes that many MBS Review Clinical Committees made recommendations, some of which have been approved or implemented by Government, that have increased the complexity of the MBS and individual items, by splitting previously single MBS items into two or more items with more detailed item descriptors, to tighten the eligible patient cohort and/or enable data capture and monitoring. For example, the colonoscopy changes, effective on 1 November, replaced four MBS items with eight new items that reflect clinical indications for the service and surveillance intervals. This could lead to additional burden on the doctor in identifying the correct MBS item to claim and for the patient to understand what medical service they were billed. It also runs counter to Principle 12 on page 38 that supports implementation of the MBS that "inhibits listing of multiple items for single consultations/treatments".

For example, new MBS colonoscopy item 32222:

> Endoscopic examination of the colon to the caecum by colonoscopy, for a patient:
> (a) following a positive faecal occult blood test; or
> (b) who has symptoms consistent with pathology of the colonic mucosa; or
> (c) with anaemia or iron deficiency; or

(d) for whom diagnostic imaging has shown an abnormality of the colon; or
(e) who is undergoing the first examination following surgery for colorectal cancer; or
(f) who is undergoing pre-operative evaluation; or
(g) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient's previous colonoscopy; or
(h) for the management of inflammatory bowel disease
Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.)

MBS item 32224:

Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a moderate risk of colorectal cancer due to:
(a) a history of adenomas, including an adenoma that:
(i) was greater than 10mm in diameter; or
(ii) had villous features; or
(iii) had high grade dysplasia; or
(iv) was an advanced serrated adenoma; or
(b) having had a previous colonoscopy that revealed 5 to 9 adenomas, each of which was less than 10mm in diameter, had no villous features and had no high-grade dysplasia
Applicable only once in any 3 year period (Anaes.)

The AMA cautions the Consumer Panel and the MBS Review Taskforce in redesigning the MBS for the purposes of data capture and analysis, that results in a more complex and unwieldy schedule, when its primary purpose is simply to provide medical practitioners with a list of medical services that are eligible for patient Medicare rebates.

The AMA is also concerned that Principle 8 is related to Recommendations 12, 13 and 14 of the MBS Review Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC) report, which the AMA strongly opposed. These recommendations proposed to establish a national minimum data set to:

- inform evidence-based clinical practice and inform patient choice;
- provide transparency on the cost and quality of consultant specialist services; and
- improve informed patient consent and shared decision-making practices.

As stated in AMA's response to the SCPCCC report, the Taskforce is tasked to consider how items on the MBS can be better aligned with contemporary clinical evidence and practice, and improve health outcomes for patients, and identifying whether there are any services that are obsolete, outdated or potentially unsafe. Recommendations 12 and 13 of the SCPCCC are significant reforms that should be discussed via an alternative mechanism to the MBS Review. There are significant risks to collecting, interpreting and presenting complex process and outcomes data, with limitations and caveats that need be considered. The AMA maintains it is potentially dangerous to present such complex and imperfect data to members of the public, where we know health literacy is variable. Furthermore, this work appears to not consider in detail the work done already by AIHW, ACSQHC and in the private health space.

The AMA sees the long-term merit in establishing a national minimum data set, but such a data set should never be used to drive and/or prescribe clinical scope of practice. The idea that all

clinical variation is bad is naïve at best and potentially detrimental to patient safety. Not all clinical variation is bad. Good variation is what makes excellent patient centred care.

Bureaucratic attempts to drive clinical practice and limit clinical variation via prescriptive medicine carries a very real risk that services will be provided to patients that do not need it, and treatments withheld from patients who would benefit. In either case the impact on patients is negative.

The AMA has consistently advocated on behalf of consumers through its formal responses to the significant number of MBS Review clinical committee reports, representations to the Department and Minister for Health and through media advocacy. Demonstration of this advocacy can be found on the AMA website, for example at: https://ama.com.au/mbs-review-ama-submissionshttps://ama.com.au/ausmed/mbs-review-changes-phototherapy-items and https://ama.com.au/ausmed/advocacy-mbs-review-changes-spinal-items

Contact

Ms Tham Vo
Senior Policy Adviser
Medical Practice Section
Ph: (02) 6270 5447
tvo@ama.com.au