**Memorandum to Participants of the MBS Review Taskforce July 2015 Stakeholder Forums**

Thank you for your participation in the Medical Benefits Schedule (MBS) Review Taskforce Stakeholder Forums in Canberra (8 July 2015), Adelaide (24 July 2015) and Perth (25 July 2015). As we commence our review of the MBS, your feedback and guidance will help shape our approach and enable us to rapidly focus on the highest areas of need.

We thought it might be helpful to send you all a brief summary of the discussion from our first set of consultation forums, in order to provide a foundation from which we can continue our dialogue with you on this important review. We look forward to continuing our discussions.

## Context and Purpose

We commenced our discussion with an overview of the state of our health system. Across the Organization for Economic Cooperation and Development countries, Australia shares the second-highest life expectancy at birth, and has the fourth-highest self-reported health score. While there are a number of drivers of these outcomes, our health system is a material contributor.

However, we face some strong headwinds. The number of services per capita is growing, particularly in the >80 years of age segment of our population. Similarly, our healthcare expenditure is rising at 7% p.a., far faster than Gross Domestic Product, and total expenditure has more than doubled since 2004. Beyond these macro trends, there are a number of specific reasons that make this the right time to review the MBS – obsolescence, indication creep, inappropriate frequency/intensity, pricing failure and potential bundling/unbundling of items.

## Scope, Outcomes and Timing of Review

In terms of the **scope** of the MBS review, the below summarises our mandated scope of the Review:

- All current MBS terms and the services they describe
- Increasing the value derived from services
- Concerns about safety, clinically unnecessary service provision and concurrence with guidelines
- Evidence for services, appropriateness, best practice options, levels of frequency of support
- Legislation and rules that underpin the MBS

We also noted there were a number of areas that were out-of-scope for the review. Specifically, excluded from the scope of our review are division of responsibilities between Governments (Federation White Paper), innovative funding models for chronic and complex (Primary Health Care Advisory Group), and the introduction of new MBS services (Medical Services Advisory Committee).

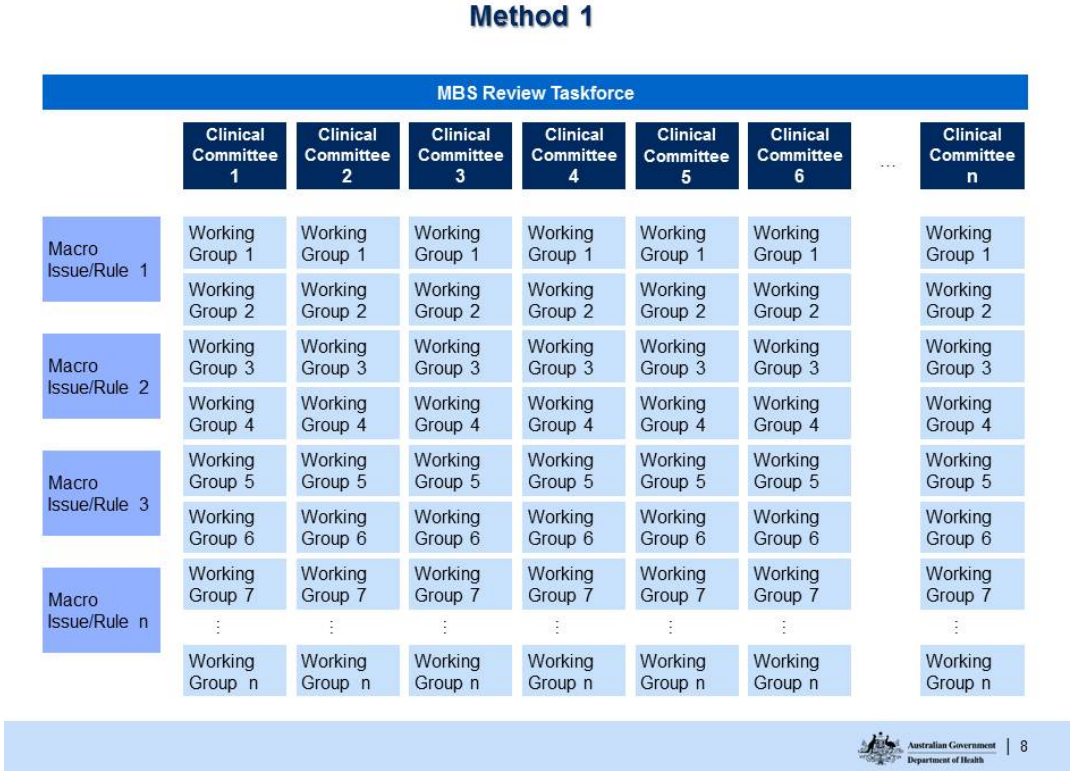
Two other important themes of the Review were also highlighted – (i) there is no savings target – the review is focused more on how we get more value out of our healthcare spend, and (ii) we need to look to the full breadth of the $19.1 billion MBS spend, not just General Practitioner services.

In terms of the **outcomes** of the MBS review, we identified six specific outcomes – identify major MBS issues, triage items for review, rapid review of relevant items, recommended changes to items, recommended changes to systems and rules, and embedding an ongoing review processes.

In terms of the **timing** of the MBS review, we have concluded a period in July 2015 of conducting several stakeholder forums, with the goal releasing/publishing a Consultation Paper in September 2015. This will then lead to a 1st Interim Report to Government in December 2015, which will also lay the foundation for the bulk of our review during 2016. We anticipate the 2nd Report to Government will be submitted in December 2016.

**Governance of Review**

We discussed the importance of breaking down the 5,769 items (as of 1 April 2015) on the MBS into "Clinical Committees", consisting of 5-10 clinical experts each, to spread the workload and allow us to accomplish our objectives, as shown below:




One goal of our early stakeholder forums was to define the specific "Review Working Groups" which are needed within each "Clinical Committee", as well as the "macro issues" which straddle many of the discipline groups.

Finally, we discussed the need to follow a "rapid review" approach within each Clinical Committee, noting that the current MSAC review processes cannot be replicated for all items within the review period. Leveraging existing work (e.g. Choose Wisely") will also be important.

**Input on specific questions**

We discussed 5 specific questions in our workshop:

- *What are the major shifts we need to make to how the MBS works?*
- *What specific issues should the review consider?*
- *What barriers will we need to address in changing the MBS?*
- *How should we prioritise where to focus?*
- *What are the most effective methods for consulting stakeholders?*

Below is a brief summary of your input on each of these 5 questions.

*Question 1: What are the major shifts we need to make to how the MBS works?*

We commenced our detailed discussions identifying our individual aspirations for the MBS, and then sharing them collectively with the group. The below table highlights the major "from-to" shifts we discussed:

| **From…** | **To…** |
|---|---|
| A focus on sickness | A focus on wellness |
| Rewarding activities and tasks | Rewarding outcomes |
| An opaque system with poor data linkages | A transparent system which is evidence-based and data-driven |
| A siloed, modality-specific view | A system-wide view |
| A static, inflexible schedule | A dynamic, flexible schedule |
| Misalignment with cost of delivery | Pricing consistent with cost of delivery |
| A dense and lengthy schedule | A simple and short schedule |
| Inconsistent pricing for items across settings of care and providers | Consistent pricing of items across settings of care and providers |
| A conservative approach to new technology | Embracing new technology |
| Consumer views not consider | Consumer views a core foundation |

In acknowledging the above desired shifts, we also noted that ~70% of the items on the MBS have not been reviewed since 1984, and that this was a unique opportunity to lay the foundation for a greatly strengthened MBS for future years that could continue to learn and evolve without the need for lengthy future reviews.

*Question 2: What specific issues should the Review consider?*

We had a broad-ranging discussion of the specific issues that needed to be considered as we look to make the shifts described above. Below are some of the issues raised across the forums. This is by no means an exhaustive list, but it does start to identify some common "macro issues" which straddle Clinical Committees, as well as some "discipline-specific" issues for the respective Clinical Committee's to consider the relevance of for their area.

| **Macro Issues (dealt with centrally)** | **Discipline-Specific Issues (dealt with by Working Groups)** |
|---|---|
| Referral mechanisms and gatekeeping | Substantial mismatches between prices and cost of delivery |
| Frequency of the ongoing review of | Shift from activity to outcomes focus |

| **Macro Issues (dealt with centrally)** | **Discipline-Specific Issues (dealt with by Working Groups)** |
|---|---|
| the MBS – make it a "living document" | |
| Transparency on MBS usage and variation | Evidence base for new standards of care and technologies |
| Potential to gather data (e.g. indications) at time of submission | Ability of MBS items to support best clinical practice |

We also noted that there would likely be three types of items: (i) those that are clear and appropriate, (iii) those whose value is indeterminate (may or may not be able to be validated with data) and (iii) those whose value is low and are ineffective.

*Question 3: What Barriers will we need to address in changing the MBS?*

Having identified the major shifts we felt needed to be made, and the specific issues we needed to consider in making these shifts, we then discussed both the potential barriers we needed to overcome and how we might mitigate them. The below table highlights the major themes from this discussion:

| **Potential Barriers** | **How We Might Overcome** |
|---|---|
| Scepticism on the political commitment and will | Communication of commitments from political leadership and case for change |
| Lack of clarity on purpose / goal of review | Clear narrative – why we are doing the review, and why now |
| Lack of research / evidence | Build the review "behind the evidence" |
| Poor data availability to inform review | Use data we have more effectively, and gather data we need |
| Inertia and behaviour change resistance | Strong change management – role modelling, investment in systems, articulation of case for change and financial benefits |
| Magnitude of change | Thoughtful implementation plan |
| Financial implications to livelihood | Ensure sustainable business models for providers |
| Complexity of services | Focus on quick wins with simple services |

*Question 4: How should we prioritise where to focus?*

We discussed the complexity in determining how to prioritise our focus across 5,769 (as of 1 April 2015) MBS items.

There were several suggestions for how we might, at a high level, break the items into natural groupings which can then be prioritised – disease types, patient types, CRAFT groups, areas where the care model is rapidly changing, and areas with poor outcomes. We also discussed looking at items from a lens of variation by provider, which in turn might inform which items require a more immediate review. All of these approaches to groupings have benefits and disadvantages.

There were also a range of criteria proposed, against which we could assess the groups/procedures to assist in their prioritisation – high cost/high volume, pace of growth, degree to which obsolete, consensus views across medical experts, complaint volumes, variation by geography, and feasibility.

*Question 5: What are the most effective methods for consulting stakeholders?*

We discussed a potential approach for consulting three types of stakeholders – consumers, clinicians, and other groups.

For consumers, we emphasised the need to use focus groups, citizen juries, social media, and case studies. We highlighted the need to co-design with consumers, not just "engage" them. We also discussed the value of informing the consumers before we engaged them, to ensure their input was focused and high impact, as well as considering engaging "expert consumers".

For clinicians, we discussed the need to leverage traditional channels such as conferences, peak associations, Colleges and Boards. Leveraging case studies and written submissions were also discussed, as was the need to provide adequate time for review and response to written reports / papers (2-3 months). We also discussed the value of role-modelling and the need to engage "champions", and to focus on engaging the next generation of clinicians.

For other stakeholders, we discussed the value of pro-actively engaging and educating the media, as well as preparing communication tools such as question-and-answer documents.

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We thank you again for taking the time to provide your input to our process. While this memorandum does not provide an exhaustive list of all your input, as noted above we hope it provides a platform for our future conversations. We would also welcome any further thoughts you may have via the official email address (MBSReviews@health.gov.au).

Many thanks again, and we look forward to our future discussions.

Professor Bruce Robinson

Chair, MBS Review Taskforce

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