

Medicare Benefits Schedule Review Taskforce

CONSULTATION PAPER: OVERVIEW

SEPTEMBER 2015

Message to the reader from the MBS Review Taskforce Chair

First of all, thank you for your interest in the Medicare Benefits Schedule Review and (hopefully) your input to its modernisation.

We have all been given an important opportunity to contribute to the improvement of our Medicare Benefits Schedule (MBS). As you will discover by reading the attached paper, the MBS is a very important part of our overall health system and it has largely served us well since its introduction in 1984. However, in recent years it has become increasingly apparent that the MBS is not always consistent with the latest clinical practice, or the best value healthcare. There are numerous examples that highlight the need for a comprehensive review.

Medicare services (MBS Items) will be reviewed by many clinicians and other experts in the relevant fields, using the latest findings from research here and around the world. Consumer representatives will also be part of this process. Proposed recommendations will be made public and consumers will be given an opportunity to provide feedback which will ensure the MBS Review Taskforce is aware of any potential impact on the patient experience.

This consultation paper and your submissions are an important part of gathering this input. In particular we are looking for examples that you have seen where the MBS seems to be failing to support delivery of best value healthcare. We are also looking for recommended improvements to the surrounding 'rules', processes and systems that support the MBS.

I look forward to reading your comments and together generating a set of high-quality recommendations that support the best patient outcomes for our health spend.



Bruce Robinson

Introduction

On 22 April 2015 the Australian Minister for Health, the Hon Sussan Ley MP, announced the formation of the Medicare Benefits Schedule Review Taskforce (the Taskforce) and the Primary Health Care Advisory Group (PHCAG), as part of the Government's Healthier Medicare initiative (health.gov.au/internet/main/publishing.nsf/Content/healthiermedicare).

The Taskforce will review the Medicare Benefits Schedule (MBS)¹ in its entirety, considering individual items as well as the rules and legislation governing their application, with the overarching goal of promoting the provision of the best patient outcomes for our health expenditure. Modernising the MBS along these lines will contribute both to the health of all Australians and the long-term sustainability of Medicare.

Why do we need an MBS Review?

The current MBS was introduced along with Medicare in 1984, based on earlier schedules dating back to 1953, and has grown significantly in size since then. There are currently 5,769² MBS items. The vast majority of these are long-standing, and only a small proportion of the services funded have undergone the type of evidence-based assessment which new services undergo before they can be added to the MBS. 70 per cent of MBS items have not been changed since their introduction, while medical practice has advanced in response to new evidence and new technologies.

The Taskforce

Chaired by Professor Bruce Robinson, Dean of the Sydney Medical School at the University of Sydney, the Taskforce's membership includes doctors working in both the public and private sectors with expertise in general practice, surgery, pathology, radiology, public health and medical administration. There is also a consumer representative on the Taskforce as well as members who have academic expertise in health technology assessment. Information on taskforce members is at [Attachment A](#).

Vision

The Taskforce proposes that the vision for the MBS be:

The Medicare Benefits Schedule provides affordable universal access to best practice health services that represent value for the individual patient and the health system.

Terms of reference

The Terms of Reference for the review are set out at [Attachment A](#).

Submissions process

Key aspects of the MBS Review are that it is clinician led with strong consumer involvement, and involves comprehensive and ongoing stakeholder consultation. This consultation process commences on Sunday, 27 September 2015 and closes at 5.00 pm (Australian Eastern Standard Time), Monday, 9 November 2015.

¹ The MBS is a key component of the Medicare system. It lists all the services that you can receive money back from Medicare for. This includes out-of-hospital services provided by GPs, specialists, optometrists, and in some cases, dentists and other allied health practitioners, and where you are a private patient having in-hospital treatment (for example, you have a baby as a private patient in a private hospital).

² This count is as of 1 April 2015, and excludes the 15 bulk billing incentives items which are administrative items.

There are two elements in the submission process: an online feedback tool (the Citizen Space Survey Tool) and written submissions. The online tool is available at [Healthier Medicare](http://www.consultations.health.gov.au/medicare-reviews-unit/mbs-review) on the Department of Health website. (www.consultations.health.gov.au/medicare-reviews-unit/mbs-review)

It is designed to collect core information relevant to the Taskforce's work, including feedback from consumers about their experiences with the MBS and MBS 'rules' and what information consumers need to make decisions about their health care. This tool's format will assist in the collation of responses for referral to the Taskforce, and if you are considering writing a submission you are strongly urged to complete the Citizen Space questions appropriate to you. On completion of the online tool, you will have the option of uploading a more detailed submission.

To assist in the preparation of submissions, this paper provides more information on the Review, highlighting issues of particular interest to the Taskforce. Note that a longer version of this paper with additional information is available at the [Medicare Benefits Schedule Review Taskforce](http://health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce) page on the Department of Health website (health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce)

Submissions must be provided in writing and must identify the name/s of the party/ies and/or organisation/s they represent (if any), as well as contact details.

If you have any questions about the submissions process or the Review in general, please contact mbsreviews@health.gov.au or (02) 6289 5151.

All comments and submissions received by the closing deadline will be reviewed and provided to the Taskforce. Submissions may be made public and shared with relevant Commonwealth, State and Territory government agencies to inform consideration of any proposed changes.

If you want your submission to remain confidential please mark the submission as such.

Important note: It is important to be aware that confidential submissions may still be subject to access under Freedom of Information law.

Background—Medicare and the MBS

Medicare was introduced in 1984 as a universal system with the goal of providing Australians with affordable, accessible and high-quality health care. Services under Medicare include:

- fully or substantially subsidised out-of-hospital (non-admitted) services provided by private practitioners such as general practitioners (GPs), specialists, optometrists and, in specific circumstances, dentists and other allied health practitioners;
- subsidised private patient hospital services;
- fully subsidised hospital treatment for public patients in public hospitals; and
- fully or substantially subsidised medicines through the Pharmaceutical Benefits Scheme (PBS).

Principles of Medicare

Universal access, meaning everyone is entitled to Medicare benefits regardless of their income, was a core principle of Medicare on its introduction, and remains so. Australian taxpayers contribute to the cost of Medicare through taxes, including a Medicare levy and, for people on higher incomes, an additional surcharge.

Medicare is a system for the payment of patient benefits, not a remuneration system for doctors. One of the fundamental aims of the MBS is that services you receive a Medicare benefit for should provide a health benefit and value for money.

The Medicare Benefits Schedule (MBS)

The MBS is a key component of the Medicare system. It lists services relevant to out-of-hospital services provided by private practitioners (e.g. GPs, specialists, optometrists) and private patient hospital services (e.g. when you go to a private hospital to have a baby), and allocates a unique item number to each service, along with a description of the service (the 'descriptor'). In broad terms, the types of services on the MBS include consultation and procedural / therapeutic (including surgical) services, as well as diagnostic services (e.g. x-rays, ultrasounds and blood tests). Full details of all MBS items, including numbers, descriptors, fees and Explanatory Notes are available from mbsonline.gov.au.

Subsidies for services by eligible health professionals take the form of Medicare benefits paid to the patient. The MBS sets out the 'Schedule fee' for each service and the rate/s at which the benefit for that service is to be calculated. It also gives advice on the clinical and administrative conditions (the 'rules') under which benefits can be claimed. The rates of benefit are:

- 100 per cent of the Schedule fee for general practitioner services;
- 85 per cent of the Schedule fee for other out-of-hospital services; and
- 75 per cent of the Schedule fee for in-hospital services for private patients.

The Schedule fee is a fee-for-service amount set by the Australian Government, and may differ from the provider's actual fee. The Government has no power to control the amount doctors charge. The patient must pay for any difference between the MBS benefit for a service and the actual fee charged by the doctor. This difference is known as an 'out-of-pocket' cost.

Where the health professional accepts the patient's Medicare benefit as full payment for the service, there is no out-of-pocket cost to the patient. This is known as bulk billing.

Services covered by the MBS

Currently, MBS benefits are payable for:

- consultations with doctors, including specialists
- tests and examinations by doctors needed to diagnose and treat illnesses, including various imaging services and pathology tests provided by medical specialists
- eye tests performed by optometrists
- most surgical and other therapeutic procedures performed by doctors
- specified dental items under the Cleft Lip and Palate Scheme
- consultations with psychologists
- allied health services for patients with a chronic or terminal medical condition and complex care needs.

MBS benefits are not payable for:

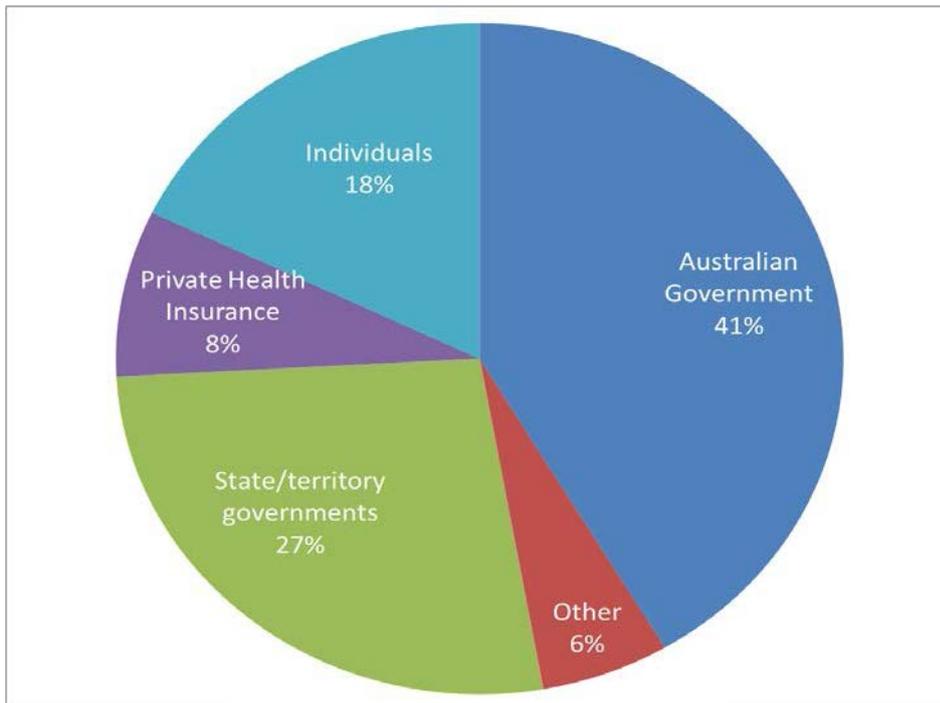
- public hospital and other services funded from another government source (some exceptions)
- pharmaceuticals (except for radiopharmaceuticals)
- dental examinations and treatment
- hospital accommodation

- medical devices and consumables (some exceptions, addressing a lack of public funding sources)
- ambulance services
- home nursing
- glasses and contact lenses
- aids and appliances
- medical services provided overseas
- medical costs for which someone else is responsible (for example a compensation insurer, an employer, a government or government authority)
- medical services which are not clinically necessary
- non-real-time care and non-face-to-face care (some exceptions)
- specifically excluded services e.g. surgery solely for cosmetic reasons
- health screening (some exceptions).³

Medicare funding and utilisation

Medicare is funded from a mix of general tax revenue and the Medicare levy/surcharge. Total Medicare expenditure in 2013–14 was \$19.1 billion (\$813 per capita, up from \$431 in 2003–4). Included in this total was the payment of Medicare benefits for 356.1 million services (15 per capita, up from 11 in 2003–4).

Figure 1: Government and private sector health expenditure 2012-13



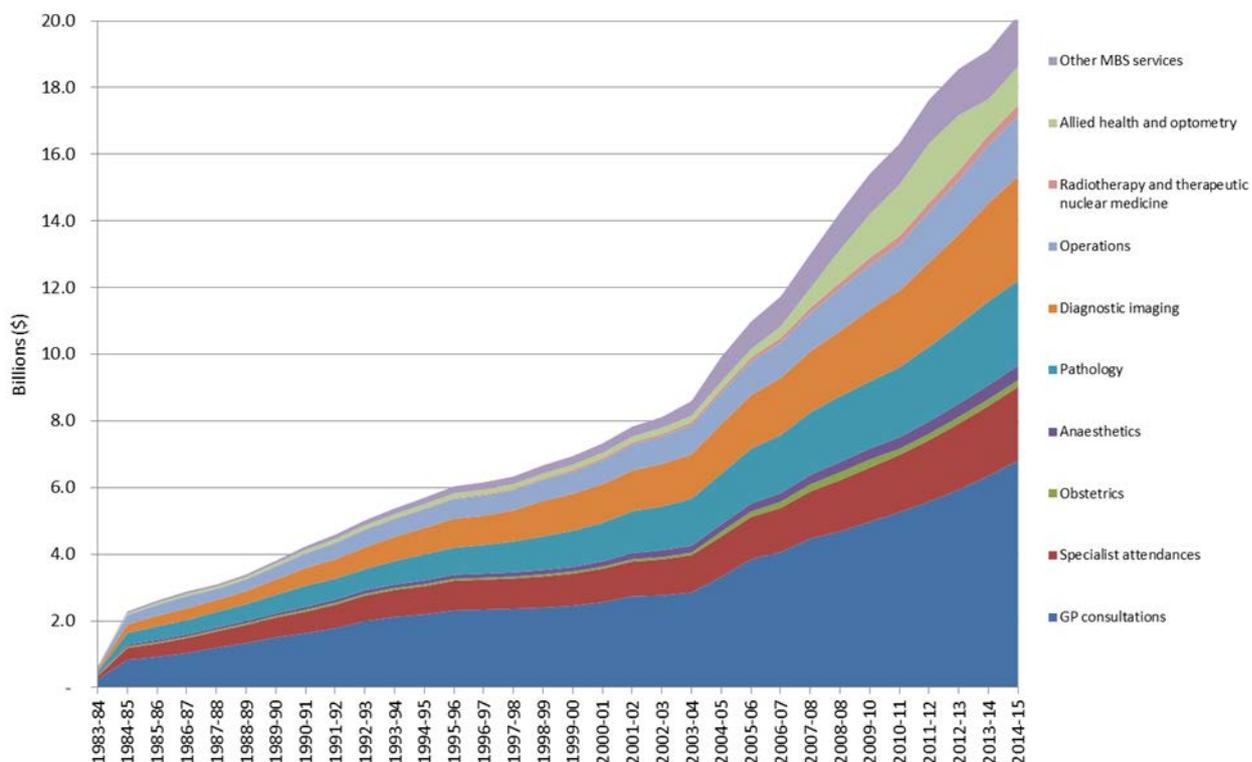
Source: AIHW Health Expenditure 2012–13

³ Medicare Benefits Schedule Explanatory notes pp.34-35
[www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/1BC94358D4F276D3CA257CCF0000AA73/\\$File/201507-MBS.pdf](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/1BC94358D4F276D3CA257CCF0000AA73/$File/201507-MBS.pdf)

Growth in Medicare expenditure

MBS expenditure since Medicare's introduction in 1984 is shown in Figure 2.

Figure 2: Benefit growth - 1983–84 to 2014–15 (\$ billion)



The MBS Review

The MBS Review aims to modernise the MBS to help achieve the following primary objectives:

- Best patient health outcomes for MBS expenditure; and
- Best evidence-based, clinical practice supported by the health professional services funded through the MBS.

A number of reviews of MBS items will be undertaken before the end of 2015, in part to test and refine methodologies for the greater part of the work to be undertaken throughout 2016. The Taskforce will submit its first (interim) report to the Government by the end of 2015 and, as a minimum, a second report by December 2016.

Review process

The major part of the Review will involve the review of MBS items by various Clinical Committees, managing Working Groups focusing on specific items. More information on this activity is given below. There will also be a review of the rules and regulations that underpin the operation of the MBS.

Clinical Committees

The Clinical Committees will be responsible for advising on the review of a group of related MBS items. Items might be related because of the patient group they affect or the professional group which provides them. Each Committee has a Chair who is a practising expert in that clinical area. Committee memberships include medical specialists from the relevant discipline/s, as well as

other clinicians (including those in related disciplines and generalists), experts in evidence evaluation, and consumers.

Working Groups

The Working Groups focus on specific issues nominated by the Clinical Committees and/or the Taskforce. Typically, this focus is on individual MBS items or groups of MBS items. The issues referred to Working Groups will be considered with regard to matters such as:

- safety;
- clinical effectiveness;
- cost effectiveness;
- frequency of use;
- the structure of items; and
- aspects of MBS funding that may drive service provision in a suboptimal way.

It is intended that all proposed changes to the MBS will be subject to public consultation before the Taskforce makes any recommendations to the Government.

Need for evidence-based reviews

One of the Review's key objectives is to eliminate the funding of low-value or inappropriate health services—that is, treatments, procedures and tests which are of little or no clinical benefit, through overuse or misuse, and which in some cases might actually cause harm to patients.

There are three potential indicators of low-value care. The first is where treatments that are proven to be of low or no clinical benefit for individuals with certain clinical characteristics continue to be provided (e.g. where research has shown that certain operations do not provide any benefit to patients for some conditions). The second is extreme variation in the provision of care across different settings (e.g. where patients living in a particular area of Australia have a much higher rate of a simple operation than elsewhere which is not explained by the characteristics of the patients). The third is where an otherwise effective test or investigation is performed at an inappropriate interval or frequency (e.g. a blood test is effective at managing a condition if it is done once a year, but it is ordered every three months which may be inconvenient or costly for patients). This category includes where patients have the same test performed, perhaps by different providers, a number of times when the results will not change the care patients are provided.

The evidence suggests that a number of services on the MBS fall into the category of low-value care. A paper published in the Medical Journal of Australia in 2012, *Over 150 potentially low-value health care practices: An Australian study*⁴, identifies 156 potentially ineffective and/or unsafe services listed on the MBS.

In Australia and internationally, considerable effort is being directed to identifying and reducing the use of low-value health care services and practice. The *Choosing Wisely* initiative is a notable international campaign aimed at eliminating unnecessary treatments, procedures and tests. Originating in the US, *Choosing Wisely* programmes now also operate in Australia and Canada, with similar schemes being established in Germany, Italy, Japan, the Netherlands, and Switzerland.

⁴ Adam G Elshaug, Amber M Watt, Linda Mundy and Cameron D Willis, Med J Aust 2012; 197 (10): 556-560.

MBS legislation and ‘rules’

Medicare and the MBS are underpinned by various pieces of legislation and it is part of the Taskforce’s role to review and recommend updates to these.

The *Health Insurance Act 1973* (the Act) sets out the broad principles and definitions governing the MBS. For example, it stipulates that Medicare benefits are payable for professional services, defined as ‘a clinically relevant service to which a MBS item applies’. A ‘clinically relevant service’ is defined as ‘a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.’

Some rules may reflect medical practice at a particular point in time and be sensitive to changes in practice. One example often raised by consumers is the rule placing a three-month limit on specialist-to-specialist referrals. Other examples of current rules include:

- patients require a referral or request from a doctor to have pathology tests or x-rays;
- some items can only be performed in a hospital for safety reasons;
- some items can only be claimed once a year by a patient; and
- Medicare benefits can be claimed for an anaesthetist and assistant surgeon for certain operations.

Consumer experiences

Consumers have different levels of health literacy and confidence, which will affect their ability to question the value of suggested tests or procedures or ask about any associated risks. Some consumers may be comfortable questioning treatment on relatively minor or ongoing conditions, but may rely completely on their GP or specialist for more serious or one-off issues.

Consumer expectations can have significant influence on what services are provided. The vast expansion in online information sources, with widely varying levels of authority and reliability, means that many patients arrive for a consultation with certain preconceptions about their actual or suspected condition and the appropriate course of clinical action. This can, for example, place pressure on doctors to request tests they might not otherwise recommend.

Consumers also often find it difficult to get clear information about how much particular services cost, with the total cost, the Medicare benefit, the private health insurance contribution (where applicable) and the out-of-pocket costs sometimes hard to understand. This can affect their ability to make decisions about their care. Even when consumers do not face any out-of-pocket costs, they may want to understand the cost to Medicare of the service they have received. Consumers may also find it difficult to get reliable information about specialists, often relying on word of mouth from other consumers.

Online questions

How has the MBS worked will or not worked well for you or someone you know? Can you give an example?

Have you or someone you know ever had a consultation, medical procedure or test you thought was unnecessary? If yes, what was the medical procedure or test, or what was the consultation of, and why did you think it was unnecessary?

Did you raise this with your doctor?

Have you ever refused or did not have a consultation, medical procedure or test because you thought it was unnecessary? If yes, what was the medical procedure test, or what was the consultation for, and why did you think it was unnecessary? Did you raise this with your doctor?

Have you encountered difficulties with Medicare 'rules'? e.g. had a Medicare benefit denied, difficulties with referral arrangements, or limits on the number of times you can access certain Medicare services in a year. If yes, please describe what happened.

What kind of information would be most useful to you in making decisions about the services you receive from health professionals?

ATTACHMENT A

Terms of Reference for the review

1. An early, high-level review of the MBS as a whole to identify priority areas taking account of factors including concerns about safety, clinically unnecessary service provision and accepted clinical guidelines.
2. From this high-level review, identify Review topics and assign priority to nominated topics, providing this initial advice to the Minister for Health by late 2015.
3. Commission evidence-based reviews that rely on assessment of literature and data by Working Groups.
4. Analyse the advice from the Working Groups and, in turn provide advice to the Minister, including advice on the evidence for services, appropriateness, best practice options, levels and frequency of support through Medicare.
5. Monitor the outcome of MBS reviews and trends in MBS growth to inform an ongoing cycle of reviews, including advising on a system of ongoing analysis of MBS data, integration of other relevant available data, policy development and implementation.
6. Advise on a departmental programme of work that aims to update the *Health Insurance Act 1973* and regulations (MBS Rules) that underpin MBS funding.
7. Provide advice to the Minister about the MBS and related health financing issues, as appropriate.
8. Engage with health consumers, medical professionals, peak bodies and other stakeholders to seek their views about appropriate review approaches and processes.

The Taskforce members are:

Professor Bruce Robinson (Chair)
Dr Steve Hambleton
Dr Matthew Andrews
Professor Michael Besser
Dr Michael Cogle
Associate Professor Adam Elshaug
Professor Paul Glasziou
Professor Michael Grigg
Dr Lee Gruner
Ms Rebecca James (Consumer representative)
Dr Matthew McConnell
Dr Bev Rowbotham
Professor Nick Talley

More information about the Taskforce's activities is available on the [Medicare Benefits Schedule Review Taskforce](http://health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce) page on the Department of Health website (health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce)