

Medicare Benefits Schedule Review Taskforce

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CONSULTATION PAPER

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.

We have designed an approach for the Review to maximise the likelihood of high-quality recommendations being implemented. Rather than a top-down approach, we are calling on many small groups of clinicians, including those operating at the frontline of healthcare, to efficiently and effectively review the available evidence and generate recommendations with input and feedback from consumers and other stakeholders.

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.

While the MBS Review is a great opportunity, it comes with significant responsibility. Through our consultation processes we hope to enhance our understanding of the cause-and-effect linkages within the health system. In this way we can minimise the unintended consequences of change and design appropriate implementation and transition plans where necessary.

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



Bruce Robinson

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1 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.

In making the announcement, Minister Ley said that the formation of these groups was in response to overwhelming feedback received during her wide-ranging consultations that Medicare's structure no longer efficiently supported patients and practitioners to manage chronic conditions or the complex interactions between primary and acute care. 'Any reform would need to have a core focus on delivering better patient outcomes, with the Government to engage doctors, patients and other health professionals to lead the broad reform process to ensure that occurs.'

The Taskforce will provide expert guidance to the Government on reshaping the MBS, while PHCAG will advise on aspects of primary care, to better support the quality of Australians' health care and the sustainability of Medicare. These groups are focused specifically on the MBS but will be informed by and form part of the reform agenda in other areas of the health care system as a whole. More information on the Taskforce is available at the [Healthier Medicare](http://healthiermedicare.health.gov.au/internet/main/publishing.nsf/Content/healthiermedicare) page on the Department of Health website (health.gov.au/internet/main/publishing.nsf/Content/healthiermedicare)

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 5,769¹ MBS items. The vast majority of these are longstanding, 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 will review the MBS 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.

An important objective of the Review will be curbing inefficiency by ensuring that low-value services—that is, services which provide no or negligible clinical benefit and, in some cases, might actually do harm to patients—cease being funded. This will allow Government investment to be directed to more effective, evidence-based services, maximising the quality and value of the health outcomes delivered by existing Medicare funding and improving sustainability, while also allowing the adoption of new health care technologies—some of which are presently not funded through the MBS but which have already been adopted as best practice.

A key part of this approach will be ensuring that MBS items are evidence-based, fit-for-purpose and reflect contemporary medical practice. An evidence-based MBS underpins best clinical practice and facilitates better health outcomes for patients.

The Review Taskforce is aware of the potential impacts of changes in medical practice across the different MBS classifications, for example, where a non-invasive diagnostic procedure supersedes an

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

invasive one. At the same time, the Taskforce is mindful of the potential impact of changes to the MBS on businesses providing health services, and takes this into account in its deliberations.

Key aspects of the MBS Review are that it is clinician led with strong consumer involvement, and involves comprehensive and ongoing stakeholder consultation. The Taskforce commenced this consultation process with a series of stakeholder forums held in July 2015 in Canberra, Adelaide and Perth, and continues with a public submissions process.

2 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. Consumers are specifically represented, and there is also academic expertise in health technology assessment.

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)
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)

3 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.

4 Terms of Reference

At its first meeting in July 2015, the Taskforce endorsed Terms of Reference outlining its work programme. These are:

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.

5 Submissions process

The Review provides a timely opportunity to bring the entire MBS into line with current medical best practice, and to introduce processes to keep it up-to-date. The participation of the full spectrum of stakeholders, through this submission process and other channels, has been from the outset a core element of the Review's methodology. Feedback from the stakeholder forums held in July 2015 is summarised 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)

This submission process commences on Sunday, 27 September 2015 and closes at 5.00 pm (Australian Eastern Standard Time), Monday, 9 November 2015.

There are two options for participation in the submission process: an online feedback tool (the Citizen Space Survey Tool) and written submissions. The online tool is available under the [Medicare Benefits Schedule Review Taskforce Consultation](http://consultations.health.gov.au/medicare-reviews-unit/mbs-review) in the Department of Health's consultation hub (consultations.health.gov.au/medicare-reviews-unit/mbs-review)

This has two response streams with different questions in each—one is directed at a broad audience, while the other is directed to people and organisations with a fuller understanding of the MBS. It is designed to collect core information relevant to the Taskforce's work, such as specific MBS items for priority review, as well as more anecdotal comments, especially from consumers of MBS services. This tool's format will assist in the collation of responses for referral to the Taskforce, and makers of written submissions are strongly urged to complete the Citizen Space questions appropriate for them. On completion of the online tool, the respondent will have the option of uploading a more detailed submission.

Two consultation papers are being released to support this initial MBS Review consultation process, providing information on the context for and objectives of the Review, highlighting issues of particular interest to the Taskforce. This *Consultation paper* is the more detailed of the two, and is intended for a broad audience including health care providers and others with a professional interest in the MBS, who may wish to make a substantive written submission to the Review.

A second paper—the *Consultation paper: Overview*—is essentially a condensed version of this paper, and is intended for an audience with little familiarity with technical aspects of the MBS, including

consumers of health services. That audience may wish to limit their contribution to the Review to the online survey, although they have the option of also making a written submission. This paper is available on the [Medicare Benefits Schedule Review Taskforce](#) 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.

Confidentiality of submissions

If you want your submission to remain confidential please mark it as such. It is important to be aware that confidential submissions may still be subject to access under Freedom of Information law.

6 Background—Medicare and the MBS

The Australian health system overall produces relatively good outcomes by international standards, with Australians enjoying some of the highest life expectancies in the world. Medicare is the Commonwealth-funded health insurance scheme that provides free or subsidised health care services to the Australian population. It 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).

6.1 Principles of Medicare

Universality of access, regardless of a person's financial circumstances, was a core principle of Medicare on its introduction, and remains so. Australian taxpayers contribute to the cost of Medicare through a Medicare levy and, for people on higher incomes who do not have an appropriate level of private patient hospital cover, an additional Medicare levy surcharge is also payable.

Combined revenue from the Medicare levy and surcharge is not allocated directly to health, but is paid into consolidated revenue, and amounts to less than 20 per cent of total Commonwealth health expenditure. In 2011–12, \$9.1 billion was raised by the Medicare levy and surcharge, but the Australian Government spent \$59.5 billion on health overall, including \$17.6 billion on Medicare benefits.

Medicare is a system for the payment of patient benefits, not a remuneration system for doctors. The Schedule fee is not intended to—and cannot—prescribe the payment to the health professional for a particular service. However, the level of benefit for a particular service can influence the billing

practices of doctors, particularly for disadvantaged patient groups or in areas of practice where there are high levels of professional and/or geographic competition.

The original aims of Medicare included supporting a fee-for-service structure for a comprehensive range of services, providing health benefit and value for money, and that service provision and pricing should support high-quality service provision.

6.2 The Medicare Benefits Schedule

The MBS is a key component of the Medicare system. It lists out-of-hospital services provided by private practitioners as well as private patient in-hospital services, 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. 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, as well as providing guidance on the clinical and administrative conditions 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 set by the Australian Government, and may differ from the provider's actual fee. Although Medicare is a public scheme, the health professionals providing the services for which benefits are paid are engaged in private businesses—either self-employed, in partnerships or, increasingly, in corporate entities small and large. Under the Constitution, the right of medical or dental professionals to set fees at their own discretion is guaranteed. The patient is liable for any difference between the MBS benefit for a service and the actual fee charged by the health professional. This difference is known as an 'out-of-pocket' cost.

Where the health professional accepts the patient's assigned Medicare benefit as full payment for the service, there is no out-of-pocket cost to the patient. This is known as bulk billing. The bulk billing rate across all MBS services in 2014–15 was 77.6 per cent. Rates in the same period for specific sectors were:

- | | |
|-------------------------------|---------------------------|
| • GP attendances ² | 83.0 per cent |
| • pathology | 87.8 per cent |
| • diagnostic imaging | 76.9 per cent |
| • optometry | 95.4 percent |
| • specialist consultations | 29.9 per cent |
| • operations | 41.6 per cent |
| • anaesthetics | 9.9 per cent ³ |

² Bulk billing rate for non-referred GP/VR GP. The bulk billing rate for non-referred attendances (Incl GP/VR GP, Enhanced Primary Care, Other, and Practice Nurse Items) was 84.5%.

³ Almost all anaesthesia services are provided in a hospital setting, and are therefore not classified as bulk billed even where there is no out-of-pocket cost to the patient.

6.3 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).⁴

6.4 Evidence-based funding—The Medical Services Advisory Committee

With the establishment of the Medical Services Advisory Committee (MSAC) in 1998, Australia became the first country in the world to adopt a national evidence-based approach to the public funding of health services. MSAC's principal role is to advise the Australian Minister for Health on evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures. This advice informs Australian Government decisions about public funding for new, and in some cases existing, medical services.

While MSAC's model is international best practice, two gaps exist:

- (i) services listed pre-MSAC, that have not had a comprehensive evidence assessment; and
- (ii) other uses of approved services that may be low value.

The evidence-based approach is designed to achieve a range of outcomes including optimum value for money in the Government's subsidisation of medical services, as well as prioritising the uptake of

⁴ 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)

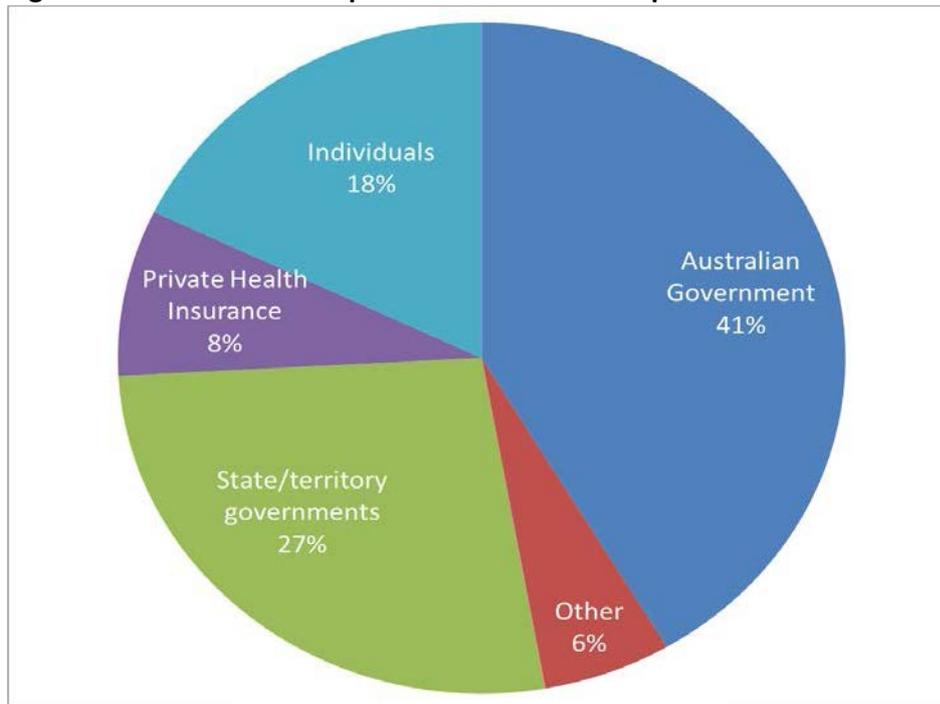
effective new technologies and procedures while avoiding the premature uptake of unproven technologies and procedures.⁵ MSAC is independent of the Government and, while it makes recommendations to the Government about the funding of medical services, MSAC itself cannot implement funding decisions.

7 Medicare funding and utilisation

Health care in Australia is delivered by a mix of public and private sector entities, and is funded by all levels of government, private health insurers, and out-of-pocket payments by individuals. The Australian Government is not directly involved in health service provision, but funds Medicare benefits, the PBS, and subsidises private health insurance premiums. It also jointly funds public hospitals with the States and Territories and provides financial assistance to residential aged care facilities and home and community care for the aged.

As Figure 1 shows, almost 70 per cent of total health expenditure in Australia is funded by the Australian, State, Territory and local governments. At \$147.4 billion, overall health expenditure in Australia in 2012–13 was 9.67 per cent of Gross Domestic Product.⁶ This is consistent with other OECD countries.

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



Source: AIHW Health Expenditure 2012–13

Medicare is funded from a mix of general revenue including the Medicare levy/surcharge. In 2014–15, \$20.2 billion was paid in MBS benefits (\$843 per capita, up from \$492 in 2004–05). Benefits were paid for 368.5 million services (17 per patient who received a Medicare service, up from 13 in 2004–05), with 89 per cent of the population accessing MBS services. Commonwealth expenditure on Medicare

⁵ Department of Health – MSAC website
www.msac.gov.au/internet/msac/publishing.nsf/Content/home-1

⁶ Australian Institute of Health and Welfare: Health Expenditure Australia 2012-13
www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548869

has more than doubled from around \$10 billion a decade ago (not adjusted for inflation).⁷

In 2014–15, 85 per cent of the population had a GP attendance (including all non-referred attendances), up from 83 per cent in 2003–04. The number of GP services per capita increased in the same period from 5.0 to 5.9. In fact, a standard ‘Level B’ GP attendance (item 23—less than 20 minutes) accounted for around a quarter of all MBS services in 2014-15 (89.3 million services) and is, by a significant margin, the most utilised of all MBS services.

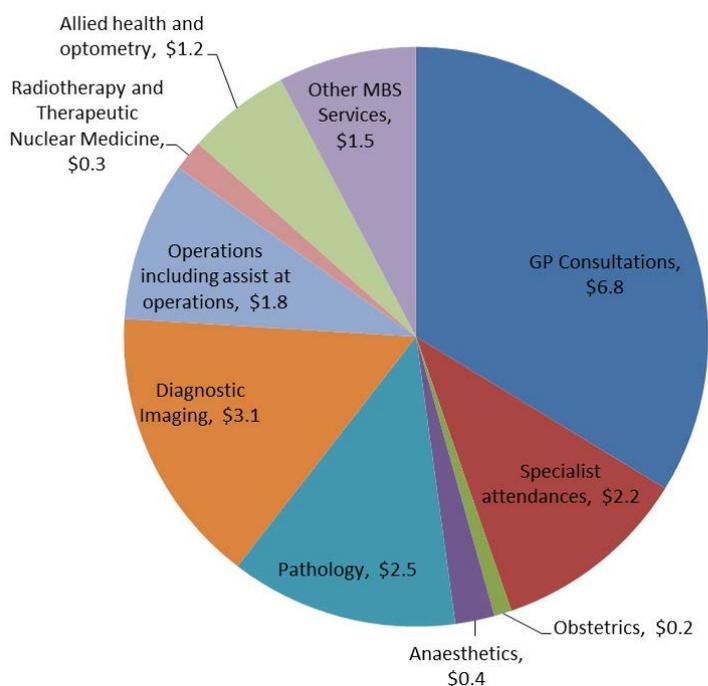
According to Bettering the Evaluation and Care of Health (BEACH) data, for every 100 GP attendances in 2013–14, there were:

- 49.1 referrals for pathology (an increase from 36.7 in 2004–05)
- 10.9 referrals for diagnostic imaging (an increase from 8.3 in 2004–05)
- 4.9 referrals to allied health (an increase from 2.7 in 2004–05)
- 9.5 referrals to medical specialists (an increase from 7.7 in 2004–05)

One or more of these actions are taken in around 75 per cent of attendances (up from around 55 per cent in 2004–05).

The proportion of the population who received a Medicare pathology test annually increased from 47 per cent in 2004–5 to 54 per cent in 2014–15, with the number of pathology tests per patient increasing from 5.8 to 7.0 in the same period⁸. The proportion of the population who received a diagnostic imaging service has also increased to 37 per cent from 31 per cent in 2004–05, with the number of services per patient increasing from 2.3 to 2.7.

Figure 2: Medicare benefits paid by type of service 2014-15 (\$ billion)



⁷ Medicare Statistics:

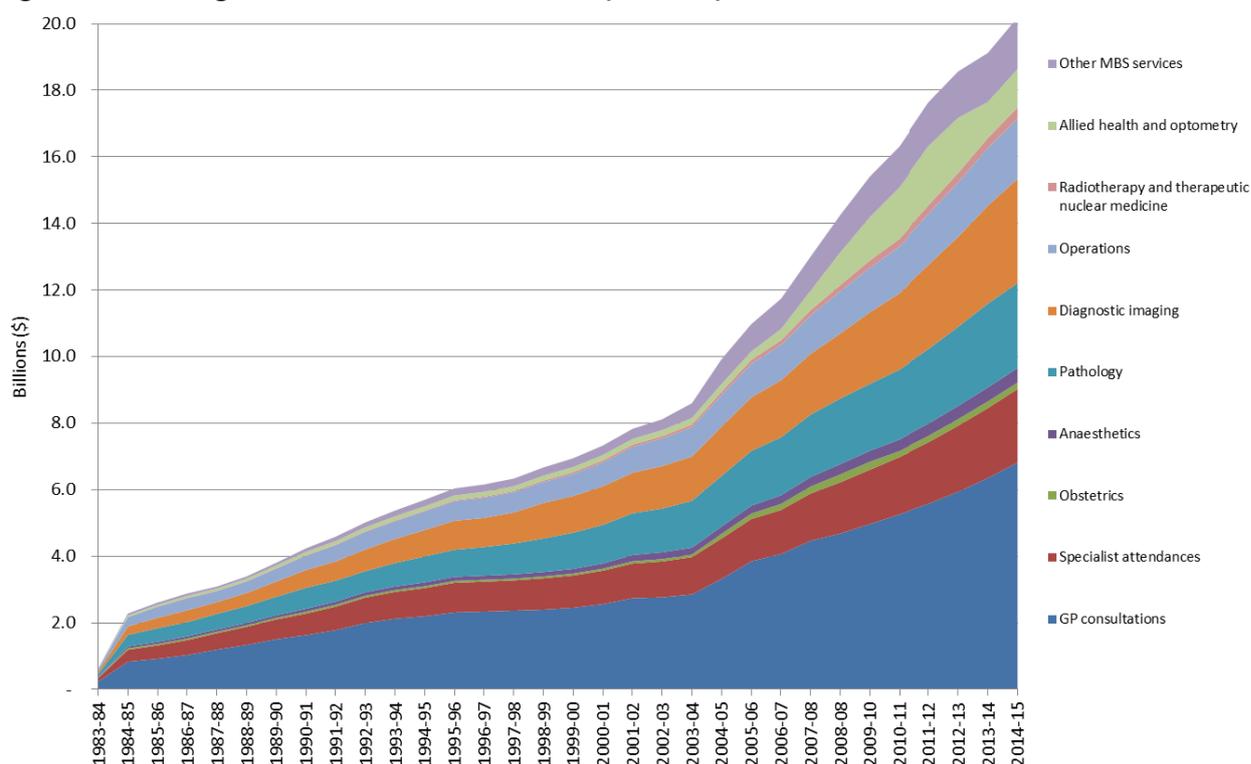
[www.health.gov.au/internet/main/publishing.nsf/Content/34A89144DB4185EDCA257BF0001AFE29/\\$File/MBS%20Statistics%20Financial%20Year%202013-14%20external%2020140718.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/34A89144DB4185EDCA257BF0001AFE29/$File/MBS%20Statistics%20Financial%20Year%202013-14%20external%2020140718.pdf)

⁸ This only includes pathology services for which a MBS benefit was paid. Note that if the Medicare processing rule known as ‘pathology coning’ is applied to a pathology claim where the tests were requested by GP, benefits are only paid for the services with the three highest MBS fees. If the data for all services affected by the coning rule was collected, this number would be higher. Coning does not apply for in-hospital patients.

8 Medicare expenditure

The MBS is an uncapped, demand-driven programme. In general, once a particular service is included on the MBS, its utilisation is largely a matter for health professionals and their clinical decision making in consultation with their patients. There are limited means by which the Government can control the use of individual items, although compliance mechanisms are in place to address obvious instances of misuse. The over-riding principle governing the eligibility of a service for a MBS benefit is that the service must be ‘clinically relevant’—that is, one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient. MBS expenditure since Medicare’s introduction in 1984 is shown below.

Figure 3: Benefit growth – 1983–84 to 2014–15 (\$ billion)



8.1 Factors contributing to Medicare growth

An increase in the population claiming Medicare

The estimated population of Australia increased from 22.03 million in 2009-10 to 23.95 million in 2014-15 (Estimated Resident Population, Australian Bureau of Statistics), an increase of 8.7 per cent. The number of people receiving Medicare services increased by 9.3 per cent between 2009–10 and 2014–15.

An increase in the age of the population

The median age (the age at which half the population is older and half is younger) of the Australian population has increased by 4.0 years over the last two decades, from 33.4 years at 30 June 1994 to 37.3 years at 30 June 2014. During the same period, the proportion of people aged 65 years and over

increased from 11.8 per cent to 14.7 percent and the proportion of people aged 85 years and over almost doubled from 1.0 per cent of the total population in 1994 to 1.9 percent in 2014.⁹

An increase in the average number of services per person

Medicare data show that per capita service use increased from 14.0 services per person in 2009–10 to 15.4 services in 2014-15 (an increase of 10 per cent¹⁰). The number of Medicare services per capita for older people is increasing at a higher rate than in other age groups. This is linked in part to the advent of new technologies and techniques which mean that procedures that once carried high risk for older patients can now be safely performed. Increased life expectancy is also a contributing factor in growth in Medicare services and expenditure.

An increase in the medical workforce

More doctors equate to greater availability of services and more people accessing Medicare services and claiming Medicare benefits. Between 2009-10 and 2014-15 the number of Medicare-eligible practitioners (including allied health practitioners) grew by over 22 per cent or 21,900 providers. The medical specialty group with the largest increase by head count of practitioners was GPs (all GPs, including non-VR GPs), which increased by about 8,100 or 15 per cent. There have also been significant increases in the specialist workforce.

An increase in the scope of the MBS

As MBS coverage increases, so does MBS expenditure. One notable addition to the MBS was the introduction of funding for allied health services in 2004. Increasing the scope of the MBS has also increased the number of practitioners that can provide Medicare-eligible services. In 2014-15, more than 45,400 'other practitioners', including allied health practitioners such as psychologists, social workers and speech pathologists, and others such as nurse practitioners and midwives provided an MBS service.

9 The MBS Review

9.1 Primary objectives

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

9.2 Secondary objectives

Where possible, the Review will also seek to make recommendations that progress the following objectives:

- clarify and align expectations of the MBS, including its scope and the rules that underpin MBS payments;
- improve alignment between need for services and access to services;

⁹ Australian Bureau of Statistics, 3101.0 - Australian Demographic Statistics, June 2014

¹⁰ Note that if multiple MBS items are claimed on the same occasion for a patient, all claims are counted as services for the purpose of this paper.

- optimise interface between MBS funded services, public and private hospitals;
- improve data collection to help inform future health service planning, without increasing red tape;
- sustained implementation; and
- ensure ongoing improvements by designing a process for the MBS to remain current.

The MBS Review approach has been designed to include a number of elements to strongly support achievement of these objectives:

- The Review is clinician led: experienced clinicians as the main source of recommendations for change ensure the highest quality advice while minimising real and perceived conflicts of interest.
- A rapid review process that has been successfully used in Ontario, Canada to ensure we get the balance of quality and efficiency in assessment of evidence right.
- Genuine, thoughtful consultation at key points in the process with all relevant stakeholder groups including the AMA, professional organisations, patient groups and consumers, to ensure that all key issues have been taken into account.

These objectives and the Review's Terms of Reference have been distilled into six specific activities:

1. Identify and prioritise MBS issues requiring action
2. Triage specific items for review
3. Conduct rapid reviews of items using Clinical Committees, managing Working Groups focusing on specific items (including stakeholder consultation)
4. Recommend changes to item descriptors and/or values
5. Recommend changes to rules and regulations that underpin the operation of the MBS, by a Macro-Issues Committee to address inconsistency, remove ambiguity and enhance compliance (including stakeholder consultation)
6. Embed processes for on ongoing review of the MBS

A number of reviews 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.

10 Review process

The major part of the Review will involve the review of MBS items by various Clinical Committees, supported by 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, by a Macro Issues Committee.

10.1 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. Members will be required on their appointment to confirm that no conflict of interest (real or perceived) exists, or is likely to arise, in relation to their work on the Committee, and must notify the Department of Health if any conflict does arise.

Clinical Committees will be responsible for considering all the MBS items in their remit and advising on which items are, and are not, in need of more detailed review (as discussed below), as well as identifying items which may need minor amendment and items which are potentially obsolete by virtue of very low utilisation in current practice.

10.2 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.

Where possible, each Working Group is chaired by a member of the parent Clinical Committee. Like the Committees, Working Groups may also include individuals from areas outside the field of medical practice immediately related to the MBS items under consideration, as well as consumer representation.

10.3 Rapid reviews

In many cases, the review of MBS items will require an evaluation of the evidence for the relevant service's safety, clinical effectiveness and/or cost effectiveness. Given the Taskforce's remit to review all 5,769¹¹ MBS items in a relatively short timeframe, it will be essential that these reviews are done efficiently, consistent with reliable and useful results. To achieve this, the Review will adopt where appropriate an approach known as the 'rapid review.'

Rapid reviews are conducted when a summary of the evidence for an intervention is required in a very short timeframe—between two and four weeks. The leading exponent of the rapid review process is Canada's Health Quality Ontario (HQO), which has successfully completed a number of reviews using this methodology. Detailed information is available at:

hqontario.ca/evidence/evidence-process/appropriateness-initiative

Rapid reviews employ many of the techniques and tools employed in standard systematic reviews of evidence. A key element of the HQO approach is an initial scoping exercise for each review, resulting in a focused question for the review. Another common feature across HQO reviews is an expert panel for each review. Working Groups would perform this role, ensuring that the review reflects best clinical practice and draws valid conclusions from the available evidence.

A systematic literature search is then conducted to identify relevant systematic reviews, health technology assessments, and meta-analyses. The search prioritises systematic reviews, which, if found, are rated by AMSTAR (Assessment of Multiple Systematic Reviews) to determine their quality. If the systematic review has evaluated the included primary studies using the GRADE (Grading of Recommendations Assessment, Development and Evaluation) Working Group criteria (www.gradeworkinggroup.org/index.htm), the results are reported and the rapid review is complete.

¹¹ This count is as of 1 April 2015, and excludes the 15 bulk billing incentives items which are administrative items.

If the systematic review has not evaluated the primary studies using GRADE, the primary studies in the systematic review are retrieved and the GRADE criteria are applied to two outcomes. If no systematic review is found, then randomised controlled trials or observational studies are included, and their risk of bias is assessed.

10.4 Scope considerations

Importantly, it should be noted that the focus of the Review is on existing MBS services, although there is scope for amended or new items. MBS items are administrative objects comprising the item number, descriptor, Schedule fee etc., whereas MBS services are the actual medical consultations, procedures, tests etc. to which items refer. The Review may well recommend changes to existing items, or the introduction of new items, where these relate to existing services.

The consideration of entirely new services for inclusion on the MBS will be managed as usual by the Medical Services Advisory Committee.

The addition of MBS benefits for new provider groups is outside the Review's scope. Another issue which falls outside the scope of the Review is the allocation between Federal, State and Territory governments of roles and responsibilities in health care.

10.5 Public consultation prior to recommendations to Government

A typical Review process will involve an issue being referred from the Taskforce to a Clinical Committee, and then to a Working Group. The Working Group's findings will then be referred back up this line. There may well be variations on this process including, for example, where a Clinical Committee deals with an issue without reference to a Working Group.

A constant feature of the Review will be that the issues raised in findings presented to the Taskforce, including changes to item descriptors and Schedule fees, will be subject to public consultation before the Taskforce makes any recommendations to the Government about actions affecting the MBS.

11 The Review—Issues for stakeholder comment

The sections following set the high-level context in various areas of the MBS and identify specific issues on which the Taskforce is seeking the views and comments of stakeholders. The 'Online questions' raised mirror the questions in the Citizen Space Survey Tool. The 'Additional issues' raised below are for response in these submissions as appropriate. Respondents may wish to consult the sources of Medicare and other relevant data and information listed in [Attachment A](#).

Parties are encouraged to focus their comments on issues directly related to the Taskforce's objectives. This will not only provide maximum assistance to the Taskforce, but will also avoid unnecessary effort on the part of submitters.

The overall objective of the Australian health system is that people have access to affordable, high-quality health care. The MBS has a key role to play in achieving this objective.

Access and affordability are obviously closely linked, and there are a number of factors which can have an impact. Affordability affects access through out-of-pocket costs. These are more likely to be zero or low for GP, diagnostic imaging and pathology services, and more likely to be higher for specialist services. Equally importantly, Australia's size and population distribution mean that a person's geographic location alone might make physical access to MBS services difficult if not impossible.

The MBS is based on fee-for-service, where patient benefits are paid for specific activities. While administratively simple, and providing strong incentives for access and efficiency, a fee-for-service approach also promotes emphasis on activity rather than outcome, and episodic rather than coordinated, multidisciplinary care.

The current system largely links payment to an interaction between a doctor and a patient, when the actual service involved might be provided by another health practitioner employed by the doctor.

For instance, although there are a variety of case conferencing items on the MBS, it is very likely that these are not used optimally because they do not engage smoothly with a model that is based on intermittent interactions between a clinician and a patient.

One of the issues already identified by stakeholders is the growing use of multiple items for one episode of care provided on the same day by one practitioner. This can seem unfair both for patients, if it does not meet with their expectations, and providers, as different total benefits apply for what are similar services.

There is a view that an item (particularly in surgical practice) should, where possible, represent a 'complete medical service'. However, there is evidence of considerable variation between providers in how item numbers are used for the same service.

It may be useful to consider introducing bundled payments for some specialist services, where care continues over a discrete period of time. This approach is used now in assisted reproductive technology services and could be contemplated in areas such as obstetrics and some cancer treatment services.

Online questions

Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?

Do you have any comments on the proposed MBS review process?

Additional issues

Should the role of the MBS be simple that of an administrative tool, or should it be used actively to guide quality medical practice?

What can be done to reduce unexpected variation in the MBS items claimed for similar services?

What implementation issues should be considered when amending or removing MBS items?

Are there any other principles that must guide the Review?

12 Evaluating the MBS Review

The Taskforce's over-riding objective is to improve the value that is derived from MBS expenditure. An important issue to consider, therefore, is how the success of the Review in achieving this can be evaluated.

The Medicare system generates large volumes of data about benefits paid for (in-scope) health services delivered to Australians. In parallel, the health system more broadly gathers information about patient health outcomes. The difficulty is in reliably linking MBS services and items to these health outcomes given the many other contributing factors.

With this in mind, potential process measures of the Review's effectiveness might include:

- the number of reviews completed; and
- the proportion of MBS items reviewed.

Online questions

How can the impact of the MBS Review be measured?

What metrics and measurement approaches should be used?

How should we seek to improve this measurement and monitoring over time?

13 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. There are three potential indicators of possible 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. The second is extreme variation in the provision of care across different settings. The third is where an otherwise effective test or investigation is performed at an inappropriate interval or frequency (e.g. too often). This category includes the unnecessary duplication of testing.

The obvious way to address the problem of low-value services is to ensure, to the greatest extent possible, that services used appropriately are eligible for funding while inappropriate uses are not eligible. That is one of the major challenges facing the Review.

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*¹², identifies 156 potentially ineffective and/or unsafe services listed on the MBS.

A recent report by the Grattan Institute¹³ identifies treatments which should not be used on certain patients. While this report focuses on hospital care, three of the services identified are covered by MBS items. They are:

- *arthroscopic debridement for osteoarthritis of the knee (inserting a tube to remove tissue);*
- *laparoscopic uterine nerve ablation for chronic pelvic pain (surgery to destroy a ligament that contains nerve fibres); and*
- *removing healthy ovaries during a hysterectomy.*

The report found that these treatments are being provided in higher numbers than the evidence suggests they should be, and often to patients who should not receive them. There is also significant variation in their provision between the States and Territories.

Another facet of the variation issue is where there is marked variation across geographic areas for services whose efficacy is not generally open to question, including common surgical procedures. It can be problematic determining the cause of these variations and on which side of the relationship the inappropriate practice is occurring—that is, whether the patients in the high-use area are receiving too many services, or the patients in the low-use area are receiving too few.

¹² Adam G Elshaug, Amber M Watt, Linda Mundy and Cameron D Willis, Med J Aust 2012; 197 (10): 556-560.

¹³ Duckett, S., Breadon, P., Romanes, D., Fennessy, P., Nolan, J., 2015, Questionable care: Stopping ineffective treatments, Grattan Institute

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. Similarly the EVOLVE campaign led by the Royal Australian College of Physicians is bringing together medical specialists in a grassroots campaign to identify low value activities with the goal of positively modifying clinical practice.

The Choosing Wisely approach is founded on the principles of managing conflicts of interest, improving the quality of care, improving access to care, and promoting the just distribution of finite resources. It brings together clinicians and consumers and considers services which are of questionable value, to inform the decisions of clinicians and to empower consumers to participate in conversations with their doctor about their care.

These initiatives challenge the idea that, in health care, more is always better. One of the problems with a fee-for-service system like the MBS is that there is a financial incentive to provide more services, but little incentive to diagnose without testing, even where this is established to be best practice, and no financial disincentive to minimise the provision of low-value services.

Finally, internationally there is growing interest among clinical communities in defining the ‘appropriate use criteria’ accompanying certain practices. These criteria define characteristics of patients for whom particular care is most appropriate, and for whom that care ought not be provided (at all or at a given frequency, etc.). These criteria have been built by expert groups using data from health outcomes and economics research to inform (i.e. define) circumstances (patient, time, place) where care represents high versus low value.

Online questions

Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part of the Review as priority?

Which services funded through the MBS represent high-value patient care and appear to be under-utilised?

Additional issues

Should cognitive (clinical diagnostic) services receive priority attention?

14 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) in particular 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.’ⁱ

The Act also sets out eligibility criteria for health care providers wishing to provide Medicare-eligible services, and prohibits the payment of benefits in certain circumstances (e.g. for services which are wholly or partly funded from another government source).

Section 4 of the Act provides that regulations may prescribe tables of medical services—covering general medical services, diagnostic imaging and pathology—which set out item descriptors, the Schedule fee for each item, and rules for interpreting the table. These ‘table’ regulations, which are remade annually, prescribe the items which are replicated in the MBS and provide definitive advice on its operation—the Explanatory Notes in the MBS itself have no legal force. Below is a summary of the main Acts and regulations in operation for the payment of Medicare benefits.

Acts

Health Insurance Act 1973

National Health Act 1953

Private Health Insurance Act 2007

Regulations

Health Insurance Regulations 1975

Health Insurance (General Medical Services Table) Regulations 2015

Health Insurance (Diagnostic Imaging Services Table) Regulations 2015

Health Insurance (Pathology Services Table) Regulations 2015

The Review presents an opportunity not only to assess the clinical efficacy of specific services, but also to consider broader questions about the role of the MBS and the rules in MBS legislation which give effect to this role at a practical level. Some of these rules have been in place since Medicare’s introduction.

Some rules may reflect medical practice at a particular point in time and be sensitive to changes in practice. Difficulties can arise in ensuring that these rules remain consistent with current medical practice, and in ensuring that a rule intended to enforce a principle does not in practice impose undue hardship on providers or patients. One example often raised by consumers is the rule placing a three-month limit on specialist-to-specialist referrals. While the intention was to strengthen the role of the GP as gatekeeper to secondary health care, the consequence is that patients need to seek additional consultations, often clinically unnecessary, simply to renew their referral. Voluntary enrolment is being considered by PHCAG and, with better use of digital health to keep the GP informed, time-limited referrals could be re-examined as part of the Review. Other examples of current rules include:

- *The requirement that health practitioners request or refer for diagnostic and pathology tests (patients cannot self-initiate these services)—other rules stipulate who can provide these tests.*
- *The information requirements for a Medicare benefit claim form (such as patient details) before the claim is accepted and processed.*
- *Restrictions on the MBS items which can be claimed for the same patient on the same occasion of care.*
- *Criteria for services which can be provided only in a hospital, or under the auspices of a hospital.*
- *Arrangements for the payment of MBS benefits for an assistant or anaesthetist at surgery.*
- *Compliance rules for managing inappropriate or fraudulent claiming through the Professional Services Review.*
- *Circumstances under which MBS benefits are not payable, such as where a service is provided under an arrangement with the Commonwealth or a State or Territory government.*

Even prior to the introduction of Medicare, there was a strong view that there are certain types of low or zero value medical services which should not be publicly funded. Some of these services fall into the broad category of ‘health screening services’. Concerns around these services remain, particularly when their provision may be driven by entrepreneurial practice models which are not concerned with ongoing patient care.

Since 1978 the *Health Insurance Act 1973* has included a specific prohibition against the payment of benefits for health screening services. However, since that time health prevention activities have become a core component of general practice and there may be confusion between a health screening service as contemplated at the inception of Medicare and clinically necessary prevention activities such as cancer screening and cardiovascular risk modification.

Online questions

Are there rules of regulations which apply to the whole of the MBS which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

Are there rules which apply to individual MBS items which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

Additional issues

Are there existing rules which are causing unintended consequences or are outmoded and should be reviewed?

Are there alternative solutions to deliver the original intent?

In amending any existing rule/s, are there any potential adverse impacts on consumers, providers or government?

Are there any new rules which should be introduced?

Are there medical services which should not be funded for reasons other than concerns about safety and/or clinical efficacy? How can these be defined unambiguously?

14.1 MBS/public hospital interface

It is a central tenet of Medicare that Australians have the right to choose to be treated as a public patient in a public hospital, free of charge. This principle is enshrined in the National Health Reform Agreement between the Commonwealth and the States and Territories. Private patients in public or private hospitals, on the other hand, will be charged for their accommodation and treatment and are able to access MBS benefits and private health insurance to assist in meeting these costs. MBS benefits are not, however, available for public patient services.

Subsection 19(2) of the Act prohibits the payment of Medicare benefits for services provided under an 'arrangement' with the Commonwealth, the States and Territories, and a range of other bodies. Ss19(2) is intended to prevent a range of 'double dipping' scenarios, where a single service is funded twice—through a MBS benefit and also through some other form of government funding. However, it has long been the case that salaried medical practitioners working in public hospitals can also see their own patients under rights of private practice, and it is permissible to claim Medicare benefits for these services.

The evolution of these practices and the lack of transparency across the system mean again that different benefits flow to different patients for the same service, depending on local practice. Broader issues around public hospital funding are being considered through the Government's Reform of the Federation White Paper.

14.2 Compliance

As well as the activities of the Taskforce and PHCAG, the Healthier Medicare initiative also includes a programme of work to develop clearer Medicare compliance rules and benchmarks. 'Compliance' here refers to the compliance of health care providers with legislative, clinical and ethical requirements relevant to the MBS and the PBS. In the present context, however, the focus is exclusively on the MBS.

The objective of the compliance programme is to control fraudulent or clinically inappropriate behaviours among providers, and minimise the inefficient or unlawful payment of MBS benefits. This approach is central to the Government's objective of reducing waste in MBS expenditure. The outcomes of compliance activities can also inform the design of health policies and programmes, including the refinement of existing MBS items.

The compliance programme is managed jointly by the Department of Health, the Department of Human Services (DHS) and the Professional Services Review (PSR). The compliance programme must be flexible enough to achieve its objectives while allowing practitioners to exercise reasonable clinical and professional judgement and to allow benefits to be paid with minimal up-front verification so that patients can access affordable health services readily. To achieve this, a tiered approach to compliance is used, with administrative compliance activities (audits and reviews) undertaken by DHS and a complementary peer review scheme managed by the PSR. There are three key areas on which compliance activity focuses:

- Deliberate fraud, where an individual seeks to obtain a Medicare benefit by intentionally falsifying facts and/or documents. This generally involves a Medicare claim being lodged where a service was not provided, or a service being provided which does not meet the requirements of the Act and/or relevant regulations.
- Inappropriate practice, where a service is provided which is not clinically appropriate.
- Incorrect Medicare billing, where a practitioner unintentionally makes a false or misleading statement that results in a Medicare benefit being paid that is greater than the benefit which should have been paid.

Medicare systems include a number of up-front checks for every claim that is lodged (e.g. that the patient is Medicare eligible, that the doctor is a recognised practitioner, that the service is identified and item-level rules are met) before a claim is paid. Additionally, post-payment activities are undertaken by DHS which consider broader provider claiming patterns and behaviours. There are two streams:

- Medicare compliance audits and reviews, which essentially look at business processes and rules; and
- Practitioner Review Programme (PRP), which looks at clinical behaviours. Potentially inappropriate practice can be referred to the PSR for investigation. It is important to note that the '80/20 rule' requires DHS to automatically refer certain practitioners to the PSR where they have rendered 80 or more professional attendances on 20 or more days in a 12-month period.

15 **Access to MBS data**

Monitoring of MBS activity by the Departments of Health and Human Services generates a great deal of data in a range of areas, including:

- the utilisation of individual MBS items and the benefits paid, both on a broad, population-based level and also in relation to specific episodes of care;
- MBS utilisation by particular groups of providers and in particular fields of practice;
- the MBS claiming and billing patterns of individual practitioners, including bulk billing rates and out-of-pocket charges; and
- the geographical distribution of MBS activity.

These data allow analysis of long-term trends, modelling of future activity, and the monitoring of individual provider behaviour for compliance purposes. Importantly, it also allows the examination of specific services—their use in isolation, but also in conjunction with other services and their role in current medical practice. While MBS data is unarguably valuable, there is an administrative input required of providers to produce it, and the need for data must be balanced with this burden on providers.

The data collected is adequate for Medicare reporting purposes and for evaluating the impact of changes to existing arrangements. However, there are a number of limitations on the current treatment of MBS data, and on its interaction with other data sets, which constrain its potential value to administrators, consumers, researchers and public health clinicians.

MBS data is not readily linked with data from other components of the health system, including the PBS and hospitals, so it is currently impossible for a single ‘observer’ to follow the complete clinical pathways of patient cohorts through the health system. Also, while the quality of MBS services is addressed through measures such as provider credentialing and practice accreditation, it is difficult to assess the success of these measures because of the lack of patient outcomes data for MBS services.

The potential value of MBS data to consumers is also not being fully exploited. In particular, information on the variation of billing practices between providers (potentially de-identified but provided in a geographically meaningful way) could be useful in making decisions about, for example, which specialist to see.

One concern that has been raised by stakeholders is that while the MBS as an administrative data set offers significant insights into what services have been provided and paid for, there is a lack of information about why a patient required a service and what the outcome was. If this additional information were routinely collected and available (de-identified) for analysis, it could provide evidence to improve health policy in a range of ways—for example, better evidence to inform future reviews, the ability to identify patient groups who should be receiving additional care, or the ability to earlier identify the emergence of an epidemic.

However, the acquisition of more useful data through the MBS would generally require more detailed and prescriptive item descriptors, and possibly a greater number of items applying to the same service than is currently the case. This approach is at odds with the idea of a simpler MBS with less prescriptive item descriptors, allowing practitioners greater latitude in delivering a service. This approach has advantages for practitioners and is consistent with the Government’s deregulation agenda, but is not conducive to the generation of detailed data.

A current example of an outcomes-focused item is obstetrics item 16519, for which the descriptor is: ‘Management of labour and delivery by any means (including Caesarean section) including post-partum care for 5 days.’ An example of a more complex item is 11820 for capsule endoscopy, with the descriptor:

Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if

required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if:

- (a) the patient to whom the service is provided:
 - (i) has recurrent or persistent bleeding; and
 - (ii) is anaemic or has active bleeding; and
- (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and
- (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and
- (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy; and
- (e) the service is not associated with balloon enteroscopy.
- (f) the service has not been provided to the same patient:
 - (i) more than once in an episode of bleeding, being bleeding occurring within 6 months of the prerequisite upper gastrointestinal endoscopy and colonoscopy (any bleeding after that time is considered to be a new episode); or
 - (ii) on more than 2 occasions in any 12 month period

Online questions

What kind of information do consumers need to better participate in decisions about their health care?

Additional issues

Should the MBS be used to encourage more systematic collection of data?

Are there MBS items which can have health outcomes data readily linked to the provision of health care?

Should MBS items support participation in the creation or development of other data sources? e.g. myHealth Record, clinical trials, funding linked to evidence production

16 Consumer experiences

Consumer expectations can have significant influence on Medicare utilisation. The typical patient presenting for a consultation with a health professional is not, understandably, aware of or concerned about questions of health system efficiencies or the economics of Medicare funding. They are focused on their very particular concerns and are usually motivated by no other desire than to improve or cure their existing medical condition, or to have their fears about a suspected condition allayed, at minimal out-of-pocket cost. 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.

In addition, 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 request.

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.

Online questions

How has the MBS worked well 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, of what was the consultation for, 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?

Additional issues

What role and responsibilities do consumers have in facilitating the best value use of Medicare services?

Sources of Medicare data

[MBS items statistics reports](#)

medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

Monthly, quarterly, yearly services and benefits statistics by item, broad type of service (BTOS), group and demographic

[Department of Health annual Medicare](#)

[statistics](#) health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics'

Annual services, benefits, bulk billing, Schedule fee observance and patient contribution rates by BTOS, state, city, rurality, gender, age

[Department of Human Services annual report](#)

humanservices.gov.au/corporate/publications-and-resources/annual-report/resources/1314/

Medicare levy exemptions, annual services and benefits, billing type, Practice Incentive Programme payments, practice nurse payments, rural health incentives

[My Healthy Communities—National Health Performance Authority](#)

myhealthycommunities.gov.au/

Services per patient, GPs per patient, hospital visits, expenditure by patient with high/low visits, state, rurality, age, chronic disease status

[Australian Institute of Health and Welfare—Health expenditure 2012–13](#)

aihw.gov.au/expenditure-publications/

Yearly services, benefits, out-of-pocket costs, government health expenditure, GDP, inflation, expenditure per person

[National Centre for Geographic and Resource Analysis in Primary Health Care](#)

graphcdev.aphcri.anu.edu.au/RMT_au/MABEL/index.html

Interactive Australia-wide maps on GP profiles, practice profiles, GP services and population statistics by Medicare Local and year

[My Hospitals](#)

myhospitals.gov.au/

Hospital performance, waiting times, length of stay for elective surgery, emergency visits

Population data

[Australian Bureau of Statistics—Patient experience survey](#)

abs.gov.au/ausstats/abs@.nsf/mf/4839.0

Waiting time and number of visits for GPs, hospitals and specialists, ability to pay health costs, satisfaction with care by age and gender

[Australian Health Survey](#)

abs.gov.au/australianhealthsurvey

ABS data on diet, exercise, health profile, health service usage, for the general population and Indigenous and Torres Strait Islanders

[45 and Up Study](#)

saxinstitute.org.au/our-work/45-up-study/data-book/

Smoking status, drinking status, weight, height, family history, medications, chronic disease, physical activity, health rating, food consumption by age, gender

[Department of Social Services concession card statistics](#)

data.gov.au/dataset/dss-payment-demographic-data

Number of concession card holders by state, gender, marital status, age, indigenous status, postcode. Duration on income support, payment by rate, earnings by concession card

[Federal electorate data](#)

infoaus.net/seifa/fed_electorate.php

MP, population and socio-economic indexes for areas (SEIFA) distribution by Federal electorate

[My Healthy Communities](#)

myhealthycommunities.gov.au/

Provides information down to the Medical Local area including statistics on health status, hospital admissions and MBS items usage for GP services

Private health insurance data

[Private Health Insurance Administration Council](#)

phiac.gov.au/

Statistical trends in membership, benefit data by year

[Private health insurance funds information](#)

privatehealth.gov.au/

Information on private health funds; data on who and what is covered, and what is included in competing policies

International data

[OECD health spending](#)

data.oecd.org/healthres/health-spending.htm

International comparison of health expenditure (total, per capita, proportion of GDP), life expectancy, mortality, health determinates, health service usage

[Commonwealth Fund—Health system publications](#)

commonwealthfund.org/publications/view-all-reports-and-

briefs#/first=0&sort=@fdate12610%20descending&f:@ftopicfacet12610=%5BHealth%20System%20Performance%20and%20Costs%5D

US-based international comparisons. Features comparisons of effectiveness and expenditure of health services

ⁱ Health Insurance Act 1973 p.4

www.comlaw.gov.au/Details/C2014C00026/Download