An MBS for the 21st Century

Recommendations, Learnings and Ideas for the Future

Medicare Benefits Schedule Review Taskforce
Final Report to the Minister for Health

December 2020

Important Note:

This report contains the views and recommendations of the Medicare Benefits Schedule Review Taskforce. It has been forwarded to the Government for consideration.

MEDICARE BENEFITS SCHEDULE REVIEW TASKFORCE

The Hon Greg Hunt MP
Minister for Health
Parliament House
CANBERRA ACT 2600

Dear Minister,

In June 2015, the Australian Government established the Medicare Benefits Schedule (MBS) Review Taskforce to consider how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients.

The terms of reference require the Taskforce to report to the Commonwealth Minister for Health. Accordingly, on behalf of the Taskforce, I am pleased to present our final report, *'An MBS for the 21st Century – Recommendations, Learnings and Ideas for the Future'.*

The Taskforce has consulted with a broad range of stakeholders and experts. I take this opportunity to thank everyone who contributed to the Review, particularly the stakeholders and experts who were so generous with their time in meeting with the Review committees.

The Taskforce has reviewed the MBS through a wide lens that extends beyond adding, amending, removing, and updating MBS items and services, but also focuses on broader structural and whole-of-MBS issues. It has made more than 1,400 recommendations to deliver both micro and macro level reform, and many of these recommendations are already in place.

The Taskforce has also identified, over its five years of work, a range of opportunities that must be addressed to strengthen Medicare and improve health outcomes for all Australians into the future. The Taskforce commends to you these opportunities, outlined in this final report.

I thank my colleagues on the Taskforce, Dr Steve Hambleton, Dr Matthew Andrews, Professor Michael Besser, Dr Eleanor Chew, Dr Michael Coglin, Professor Adam Elshaug, Dr Tammy Kimpton, Professor Paul Glasziou, Professor Michael Grigg, Dr Lee Gruner, Ms Rebecca James, Dr Matthew McConnell, Dr Bev Rowbotham, Dr Joanna Sutherland, and Professor Nick Talley, for their contribution to our deliberations leading to the final report.

I would also like to extend this thanks to the more than 700 clinicians, consumers and health system experts who gave up their time, energy and expertise to participate in the more than 100 clinical committees and working groups that have formed the MBS Review Taskforce over the past five years. Their recommendations, many of which have already been implemented, will renew the MBS and patient care in Australia.

I also thank the Department of Health officials and particularly the members of the Medicare Review Unit secretariat who worked long and hard to assist the Taskforce over the past almost five years.

Yours sincerely,

Professor Bruce Robinson AC
Chair MBS Review Taskforce

Acknowledgements

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) wishes to thank the more than 700 clinicians, health system experts and consumers who assisted in the MBS Review over the past five years.

The Taskforce also wishes to thank the Ministers for Health for supporting this important project, the dedicated team at the Department of Health and the consultants who contributed to the Review, and all the peak medical bodies, colleges, clinicians and community members who made the effort to respond to consultation and give the Taskforce the benefit of their expertise. The Taskforce also thanks the Chairs of the committees that were critical in providing their advice.

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Prof Mark Hertzberg, Blood Products

Dr Richard Harper, Cardiac Services

A/Prof Jocelyn Shand, Cleft Dental Services

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Dr David Brazier, Diagnostic Imaging (incl Breast Imaging and Nuclear Medicine)

Prof Rachael Moorin, Diagnostic Imaging — Bone Densitometry

Prof Stacy Goergen, Diagnostic Imaging — Knee Imaging

Dr Ken Thomson, Diagnostic Imaging — Low Back Pain

Prof Alexander Pitman, Diagnostic Imaging — PE/DVT

Prof Paul Glasziou, Diagnostic Medicine

Mr Patrick Guiney, Ear, Nose, and Throat Surgery

Dr Lee Gruner, Eating Disorders

Prof Jonathan Serpell, Endocrinology

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Ms Donna Garland, Primary Care — Participating Midwife

Prof Michael Grigg, Principles and Rules

Prof Malcolm Hopwood, Psychiatry

Prof Alan Cass, Renal Medicine

Prof Anthony Lawler and Dr Philip Truskett, Specialist and Consultant Physician Consultations

Dr Michael Johnson, Spinal Surgery

Prof Christine Jenkins, Thoracic Medicine

Prof Brian McCaughan, Thoracic Surgery

Dr Steve Hambleton, Urgent After Hours Primary Care and Telehealth

Prof Mark Frydenberg, Urology

Dr Peter Subramaniam and Dr Ronald Meikle, Vascular

Dr Simon Torvaldsen, Wound Management

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Executive Summary

The Australian Government established the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) in mid-2015 to review the more than 5,700 items on the MBS. This has been the most comprehensive review of Medicare since its inception in 1984.

The Taskforce is pleased to report it has completed its work, providing the Government with more than 1,400 recommendations to strengthen, modernise and protect Australia's world class health system.

The Taskforce focused on ensuring MBS items meet the goals of affordable and universal access, best practice healthcare, and value for both the individual patient and the health system. Within the Taskforce's brief, there was also considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This included not only making recommendations about consolidating, amending and updating MBS items, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues, including alternative funding models.

This Final Report outlines the Taskforce's approach and its key achievements to date, as well as the need for continuous review and reform of the MBS, and the challenges and opportunities that lay ahead to improve the MBS within the broader health system. The Taskforce recommends implementing all MBS Review recommendations made to date, and makes further key recommendations centred on:

- Embedding a consumer-centric focus in the MBS and in any future changes.
- Improving monitoring, so data and research can be used to support practitioners in delivering care and underpin future changes to the MBS.
- Rebalancing healthcare financing from near exclusive reliance on 'fee-for-service' to complementing with 'block' and 'blended' payments in order to support more clinically appropriate modes of patient care.
- Reviewing continuously to assure the patient and community that safe, high quality and high value care is provided by the MBS.

At the outset of the MBS Review (the Review), and critical to its success, the Taskforce designed and established a process whereby clinical experts and consumer representatives came together on a regular basis to undertake clinical area-specific reviews. It formed more than 100 clinical committees and working groups, which engaged with more than 700 clinicians, health sector experts and consumer representatives. These committees included a Consumer Panel to support consumer engagement and a Principles and Rules Committee to examine and provide advice on broader questions about the principles, objectives and boundaries shaping the MBS and its impact in practice. These clinical committees and working groups investigated the needs of patients and item users, and recommended changes that better support the provision of care for those giving and receiving it.

Each clinical committee developed a report and a set of draft recommendations. These draft recommendations were assessed and endorsed by the Taskforce before being released for a comprehensive consultation process. The Review consulted broadly and deeply throughout its

five years of operation. This extensive consultation tested recommendations and explored whether they could be implemented and would deliver improved outcomes for consumers and providers.

Feedback from consultation was analysed, and where appropriate, integrated into the reports. The Taskforce presented a finalised set of recommendations to the Government for consideration. The high level of stakeholder engagement means while all the final recommendations remain the responsibility of the Taskforce, the process of producing them has been a collaborative project.

The Taskforce developed over 60 detailed clinical reports containing more than 1,400 recommendations. These will deliver important micro-level reforms to the MBS. They will deliver greater consistency and clarity across different parts of the MBS, update the system and promote better use of data and evidence to support MBS services. Already, many of these recommendations have been accepted and implemented by the Government, and the Taskforce anticipates that many hundreds more will be accepted in the coming months and years, ensuring safer, more modern care for all Australians.

Some of the key achievements include supporting GPs and improving patient access to aftercare following surgery, and enabling rural and regional patients to receive life-saving kidney dialysis in their remote communities from nurses, Indigenous practitioners and Indigenous health workers. Changes have been made to reduce unnecessary colonoscopies and improve access for patients who need them, and expand access to psychological and dietetic services for patients with severely debilitating eating disorders. Reforms have also been made to improve urgent after-hours services, which had been driven by a throughput-focused corporate model and advertised to consumers on the basis of convenience. As a result, patients now receive the most appropriate care for their medical needs. Other key achievements are outlined in the report, along with a timeline setting out how the Review moved through items between 2015 and 2020. The Taskforce is pleased that these have been actioned by Government. There are many more recommendations that require consideration and implementation.

In undertaking the Review, the Taskforce encountered and considered a range of broader system-wide issues that warrant further investigation and work to improve patient outcomes. With MBS expenditure forecast to reach over $30 billion per annum from 2022-23, it will be crucial that the MBS delivers care that is of high value to consumers, that meets their needs and is based on the latest evidence and best practice. This Report details these opportunities and challenges, and provides recommendations to address these issues and reform the MBS for the 21st century.

Creating an MBS that meets the needs of consumers

One of the key opportunities for an enhanced MBS is the continued involvement of consumers.

The Review's consumer-focused processes have helped to place consumer views at its centre and this will be crucial in the future review and reform of the MBS.

Consumers consistently raised the challenges encountered in navigating a complex, and at times fragmented, health system, with care being delivered by a multitude of service providers and funded by different levels of government. Consumers also expressed concerns about increasing out of pocket expenses and the lack of transparent information on fees, treatment options, risks and outcomes.

The Taskforce acknowledges the steps the Government has taken to reduce out of pocket expenses and provide more transparent information for consumers. The Taskforce recommended a range of actions to build on these efforts including the further investigation of the Extended Medicare Safety Net (EMSN) and mandatory provision of clear and understandable fee and treatment information to help consumers participate in decision-making about their care. The Taskforce also recommends the

creation of an independent Medical Fee Complaints Tribunal to deal with consumer grievances about high or unwarranted out of pocket medical costs.

Improved measurement of healthcare for consumers

Both consumers and providers recognised the need for better data and information on not just the health care services delivered, but the *outcomes* of such services, to ensure the provision of high value care and to reduce incidents of low value care. While the Taskforce recognises that most health care delivered in Australia does provide high value to patients, there are few examples of this being systematically recorded and analysed. There is some registry data collected but this is not always accessible to consumers, funders and other providers and its collection is not consistent across the health system.

The Taskforce recommends establishing data collection to assist with measures of outcome, risk and value. These data would enable more informed consumer choice, efficient allocation of health funding and provide better patient outcomes. This would complement the collection of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS). Building on this information would be a new set of publicly available data detailing the cost and quality of MBS services to allow consumers to more easily make informed choices about their care.

Alternative funding models to support healthcare delivery

The Taskforce frequently found the fee-for-service model was not always the most appropriate way of funding some health services. The fee-for-service basis of the MBS was established in the early 1980s and has served its purpose well. However, as health care needs have changed and become more complex, it is appropriate for health care funding systems to evolve and adapt to meet those needs.

Fee-for-service remains an important method for funding health care delivery. The Taskforce recommends it be complemented by a block or blended payment model, such as the Voluntary Patient Enrolment model referred to in the 2019-20 Federal Budget. This approach will support longitudinal care, encourage more coordinated care, better health workforce utilisation and greater fee transparency, particularly for patients with chronic disease.

The Taskforce agreed permanent financial loadings are not appropriate in the MBS fee-for-service model in the Australian context. These loadings have been provided to incentivise the uptake of new MBS services, promote service delivery in locations with access issues (such as rural and remote areas) and compensate for additional complexity or capital costs in delivering certain services. If these outcomes are warranted, it is more appropriate and efficient to target measures using non-MBS mechanisms.

The relative values of MBS rebates should also be reviewed, with a time of patient contact based realignment considered by the Taskforce to be an appropriate and fair approach. This would help to address distortions and inequities in MBS rebates, which have resulted from decades of piecemeal adjustments to the schedule, along with evolving roles and advances in technology, which can deliver practice and time efficiencies, without adjustment to rebates.

GP Stewardship

The Taskforce has reaffirmed the central role of general practitioners (GPs) in providing holistic, comprehensive and continuing care to patients which includes coordination of patient care and referral for specialist care as required. This GP stewardship role is regarded as a fundamental strength of the MBS and Australian healthcare system.

The Taskforce also recommends the expansion of the Voluntary Patient Enrolment initiative. This initiative enables block funding to general practices and supports a longitudinal doctor-patient relationship. This would be particularly beneficial for those patients with ongoing chronic and complex care needs.

Improvements to data collection and utilisation will also better support GPs in caring for their patients and in their professional practice and when shared with the Primary Health Network (PHN) support service planning and resource allocation.

Clinical Decision Support

The Taskforce has specifically recommended the development and expansion of clinical decision support tools to aid both GPs and specialists in delivering the most appropriate high value care.

Harnessing Innovation to deliver contemporary care

The pace of medical discoveries and advancement of treatment is ever increasing. Australia needs to keep pace, not only with research and innovation, but in translating those advances into practice, and where appropriate including them on the MBS for the benefit of all Australians.

Innovation is about more than understanding the latest research or new technology; it is also the process of thinking differently and with imagination to develop new approaches to health care.

There are a number of barriers in Australia preventing innovative approaches or thinking to be leveraged across the health system. These include lack of data and evidence, and the process for assessing, reviewing and introducing new technologies, approaches and models of care, which can be difficult to access and time-consuming.

To address some of these issues the Taskforce has recommended the creation of a National Institute for Health Research to support innovative change, health policy development and identify the treatments of the future. This would be a collaborative effort between the Commonwealth, the States and Territories, the private sector, the professions and consumers to deliver system wide change.

Consistency across the MBS

The Taskforce noted inconsistencies in item descriptors, rebates, co-claiming behaviours, and failure of the MBS to keep pace with advances in surgical technique. This was particularly evident during the review of the procedural based items.

The Taskforce made many recommendations for reforms in this area. It has also developed principles and shared its practical learnings to help guide clinical committees in their decision-making and inform future reviews of the MBS. These include changes to specific item descriptors, the ‘complete medical service’ principle, and recommending consistent rebates for procedures regardless of the surgical approach employed. These changes will provide greater clarity for providers and consistency for patients undergoing treatment.

Stakeholders made repeated requests for greater audit and compliance oversight of MBS utilisation by practitioners. The Taskforce acknowledges the need for compliance and supports this through an increased focus on clarifying item descriptors and recommending increased education and support for providers.

Telehealth

Telehealth was consistently raised during the course of the Review as a means of improving the MBS and harnessing technology to better provide health care, particularly for people in regional areas or with complex care needs that prevented them from attending a practice.

In the first half of 2020, as the Taskforce was completing its Review, the coronavirus (COVID-19) pandemic further highlighted the importance of telehealth. The Government responded to the need for an alternative to face-to-face care by creating more than 280 temporary telehealth items. These have been embraced by consumers and providers, and the expectation is these will continue in some form. The Taskforce has developed a set of Principles as part of its Telehealth Report to underpin and guide the ongoing use of telehealth in the Australian health care setting. These Principles will help ensure any ongoing telehealth items are used appropriately and deliver safe, quality, high value care for consumers.

Continuous Review of the MBS

Feedback was received from stakeholders on the need for a continuous review of the MBS. This is considered essential to maintain the MBS as a contemporary, fair and high value system to support the delivery of health care for Australians. The Taskforce acknowledged the effectiveness of the Medical Services Advisory Committee (MSAC) in undertaking complex health technology assessment (HTA) of potential new items, but noted in its current form stakeholders perceive its processes as a barrier to modernising the MBS. Further, it currently does not have the capacity to comprehensively review or remove existing MBS items.

The Taskforce recommends the creation of a continuous review mechanism to deliver ongoing review, amendment and (where appropriate) removal of *existing* items, in order to complement the well regarded assessments of *new* items undertaken by MSAC.

The Taskforce's view is that this would be best delivered by a new entity, a Medicare Advisory Committee (MAC), which would bring together the continuous review mechanism and MSAC roles. The MAC would streamline the processes of both, create efficiencies in the review of items and expedite the addition of new items.

This MAC would draw on a broad range of clinical, health economic and consumer expertise to inform its decisions, with overall responsibility for evaluating new applications for items to be added and reviewing existing items to replace or delete items. It would also act as a source of advice for the Government on clinical and system wide issues that arise from time to time. The membership, structure, objectives and operation of the MAC is expanded upon in Part Three of this Report.

The Taskforce wrote in its Interim Report to the Minister in early 2016:

> *'The rationale for this Review is very clear. The MBS is a key driver of the way health services are delivered into the community. Despite its importance to health outcomes and the sizeable public investment ($20 billion in 2015–16, around 30 per cent of total Commonwealth health expenditure), the MBS has never been subject to a comprehensive review. Yet over this period there have been significant changes in best medical practice.'*

Clinical practices and the use of technology change almost as fast as items can be examined. These conditions make it essential clinicians, government and policy makers provide flexibility in the ways services are subsidised and delivered through the MBS. This flexibility is critical to ensuring patients get the most up to date care and treatments whilst simultaneously managing the increased cost and demand for care, including chronic and complex health problems.

The MBS Review represented a unique opportunity to assess the effectiveness of the MBS for the first time, in a detailed way. This Final Report is now an opportunity to comment, with the benefit of five years of research, consultation and careful consideration, on the future needs of the MBS. With expenditure expected to exceed $30 billion per annum from 2022-23 (1), it is imperative to take an active interest in tackling these challenges to ensure our public insurance scheme remains sustainable for generations to come.

Implementing the recommendations of the Taskforce – from across its 60 reports, as well as this Final Report – will be challenging and require significant investment and commitment from the Government. Stakeholder expectations are high, along with the needs of consumers who rely on the MBS to provide high quality, safe, modern care. The Taskforce's combined expertise and considered advice has resulted in more than 1,400 recommendations which, when implemented, will help reform the 40 year old MBS and reposition it to provide the health care Australians need and deserve in the future.

Introduction

Over five years, the MBS Review Taskforce considered every item on the MBS, with more than 5,700 items assessed by over 700 clinicians, health policy experts and consumer representatives, supported and informed by the feedback from numerous stakeholders. The Taskforce's processes revealed it was critical to assess more than item numbers and descriptors; that reviewing the MBS required a range of issues to be carefully considered including the structure of the system, its financial sustainability and the importance of data and research.

With no comprehensive review having been conducted in the nearly 40 years since the establishment of the MBS, the need for this work was clear. Medicare and the MBS were designed in the late 1970s and early 1980s to meet the needs of a very different population. Australians are now older, living longer, and with more complex and chronic health issues, and the fee-for-service approach of the MBS needs to adapt and evolve to meet those needs.

The Review sought to place the consumer at the centre of its analysis, ensuring the system met their needs now and into the future and provides them with world class care based on the latest evidence. Health care providers were also key, as their expertise in treating patients and real world knowledge was critical in helping reshape a more effective and efficient MBS. Other stakeholders, ranging from professional peak bodies such as the Australian Medical Association (AMA), the Royal Colleges, and other professional health care organisations and associations, to individuals with concerns for their patients and practices, provided valuable insights into the practical application of recommendations and helped the Review avoid unintended consequences.

The Taskforce's Final Report first assesses the history of the MBS to highlight the need for reform before drawing together the insights gained from the five years of careful review and analysis.

Across six themes relating to consumers, data and measurement, alternative funding models, GP stewardship, innovation and consistency in surgical procedures, the Taskforce provides a series of recommendations to reform and reposition the MBS so it is able to meet the challenges of the years ahead.

The core recommendation is the creation of a continuous review process, by bringing together the Medical Services Advisory Committee's role in adding items to the schedule with the Review's ability to review, update and remove existing items. This would be a more efficient, streamlined approach, ideally providing a faster and more affordable option for stakeholders promoting changes to the MBS. The new body would also act as a source of advice for the Government on clinical and system wide issues that arise from time to time.

In the interests of protecting patient and provider safety, the current COVID-19 pandemic has forced the most significant change in the history of the MBS with the rapid expansion of telehealth. Telehealth has been embraced by the community as a means of continuing to provide quality health care, while limiting face-to-face contact. While this change occurred in the final months of the Review, the Taskforce has provided a series of principles to assist in guiding the longer term use of telehealth.

The changes demanded by the pandemic shows not only that the system is capable of change, it must adapt to meet a changing world. The recommendations in this Report will help create a more modern system, better able to meet the challenges of the future and provide the care Australians need and expect.

The Taskforce's approach

The MBS Review

On 22 April 2015, the Government announced a program of work to deliver a Healthier Medicare, which included the MBS Review (the Review). The Taskforce was asked to consider how the more than 5,700 items on the MBS could be aligned with contemporary clinical evidence and practice to improve health outcomes for patients. The Government also requested the Taskforce identify unnecessary services that may be outdated or potentially unsafe, and provide advice on a range of structural and health financing issues.

The MBS Review Taskforce

Below is a list of the 16 members of the MBS Review Taskforce:

1. Professor Bruce Robinson AC – Chair
2. Dr Steve Hambleton – Deputy Chair and representative of Primary Health Care Advisory Group
3. Dr Matthew Andrews – Clinical member (Diagnostic imaging)
4. Professor Michael Besser – Clinical member (Neurosurgery)
5. Dr Eleanor Chew – Clinical member (General practice)
6. Dr Michael Coglin – Clinical member (Private provider)
7. Professor Adam Elshaug – Health Policy Academic and Researcher
8. Dr Tammy Kimpton – Clinical member (General Practice)
9. Professor Paul Glasziou – Clinical member (General practice)
10. Professor Michael Grigg – Clinical member (Surgery)
11. Dr Lee Gruner – Clinical member (Medical administration)
12. Ms Rebecca James – Consumer representative
13. Dr Matthew McConnell – Clinical member (Public health)
14. Dr Bev Rowbotham – Clinical member (Pathology)
15. Dr Joanna Sutherland – Clinical member (Anaesthetics)
16. Professor Nick Talley – Clinical member (Medicine)

Taskforce members were selected by the Minister for Health after consultation and consideration of the breadth of appropriate skills and clinical experience required to provide expert clinical advice on the diverse items across the MBS. They served on the Taskforce as individuals, not representatives of organisations.

The Review has been clinician-led with strong involvement from patients and their representatives at all stages to ensure the schedule delivers outcomes for patients.

The Taskforce has provided recommendations to the Government that allow the MBS to deliver on these four key goals:

- affordable and universal access – by improving services for patients, particularly those in rural areas.
- best practice health services – by ensuring individual items and their descriptors are consistent with contemporary best practice and the evidence base where possible. Although MSAC plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never previously been reviewed.
- value for the patient – by supporting the delivery of services that are appropriate to patient needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- value for the health system – by reducing the volume of services that provide little or no clinical benefit, and redirecting resources to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services at present.

Achieving the above objectives will go a long way to achieving improved value for the health system overall.

The Review process

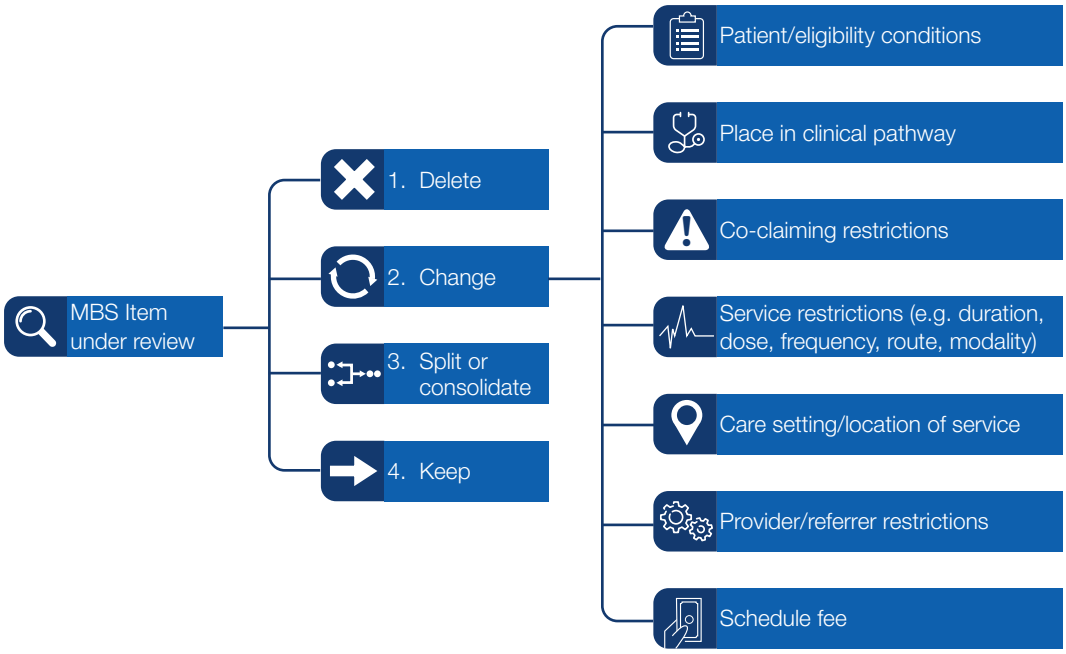
The Taskforce designed a robust process and established more than 100 clinical committees and working groups to review the existing MBS items. Over the course of the Review, more than 700 clinicians participated on these committees. Each clinical committee was chaired by a clinician expert and comprised a mix of members such as clinicians, health system experts, an ex-officio Taskforce member, and critically, a consumer representative. All committee members provided expert advice and insight to aid in the review of the items, with the consumer representative key to the success of the model by ensuring all recommendations were considered from the perspective of patients. Similar to Taskforce members, clinical committee members were appointed in their individual capacity, rather than as representatives of any organisation.

Many of the clinical committees established working or other reference groups to consider particular items or specific clinical issues. The clinical committees and working groups were supported by the Government Department of Health, which provided secretariat support, data analysis and policy information.

The committees undertook detailed reviews of items based on relevant data, literature, clinical guidelines and consultation. They considered the clinical efficacy of items, along with volume metrics and a range of issues such as safety and geographical factors.

The committees made recommendations to consolidate, amend or update existing items (this included changes to clinical pathways, referrer arrangements, care settings, claiming restrictions and service conditions such as dose and frequency), as outlined in Figure 1. The committees also made recommendations to add new items to the MBS, and to delete items considered to be obsolete, of little clinical value or that pose a risk to patient safety. In addition, the committees made recommendations about other general MBS issues identified in the course of their deliberations.

Figure 1: Types of item level recommendations, with multiple options for change



The Taskforce also established a Principles and Rules Committee (PARC) to review and provide advice on the legislative and regulatory framework underpinning the MBS, and consider broader questions about the principles, objectives and boundaries shaping the MBS and its impact in practice. PARC provided advice on a range of specific issues such as referrals between medical practitioners, the co-claiming of consultation items with procedural items in a single episode of care, and the 'complete medical service' and multiple services rule. PARC also developed principles to guide the Review's clinical committees in developing their recommendations.

Consumer engagement

The Taskforce established a Consumer Panel to support consumer engagement with the Review. The Consumer Panel facilitated effective communication, provided information on lessons learnt and made recommendations on immediate and systemic consumer related health technology considerations. It also supported the consumers on the clinical committees to contribute to the outcomes of both the clinical committees and the Taskforce.

With the Consumer Panel in place, the Taskforce has been able to capture the consumer sentiment and embed it alongside the clinician perspective, ensuring reports and recommendations reflect the impact of changes on consumers.

Consultation

Early and ongoing consultation has been integral to the MBS Review.

The Taskforce undertook extensive public consultation soon after its formation. Stakeholder forums were held in most capital cities and an online public submissions process was conducted inviting responses to an online survey and written submissions. To support this process, the Taskforce released two consultation papers: one aimed at professionals and the other aimed at consumers of MBS services. Organisations and individuals provided overwhelming support for an MBS review and identified a range of issues for examination.

With the Review under way, each clinical committee released a report in draft form for stakeholder consultation and comment. This process generated quality feedback that was generally well informed and constructive. Clinical committees then considered the feedback on its draft report before finalising recommendations to the Taskforce.

Members of the public and others also provided ongoing feedback, input or insights as the Review progressed, either in writing, meetings or in stakeholder forums.

Taskforce consideration

The Taskforce considered its final recommendations in light of clinical committee advice and, where clinically appropriate, also considered input from consultation processes.

On occasion, there have been differences between clinical committee recommendations and Taskforce recommendations. These differences have emerged out of the Taskforce's desire to minimise the complexity and ambiguity in the MBS, whilst ensuring consistency across multiple recommendations.

There have also been occasions where the clinical opinion of the Taskforce has varied from the input of the clinical committee or stakeholders. This has been one of the major strengths of the model adopted by the Taskforce and has improved recommendations, balancing the varied stakeholder expectations and the practicalities of delivering health care in Australia.

The Taskforce has worked to refine its consultation process over time. It has used the experience of undertaking a complex and collaborative project to inform its approach. This approach helped mediate the different requirements of stakeholders, resulting in a high number of recommendations to the Government.

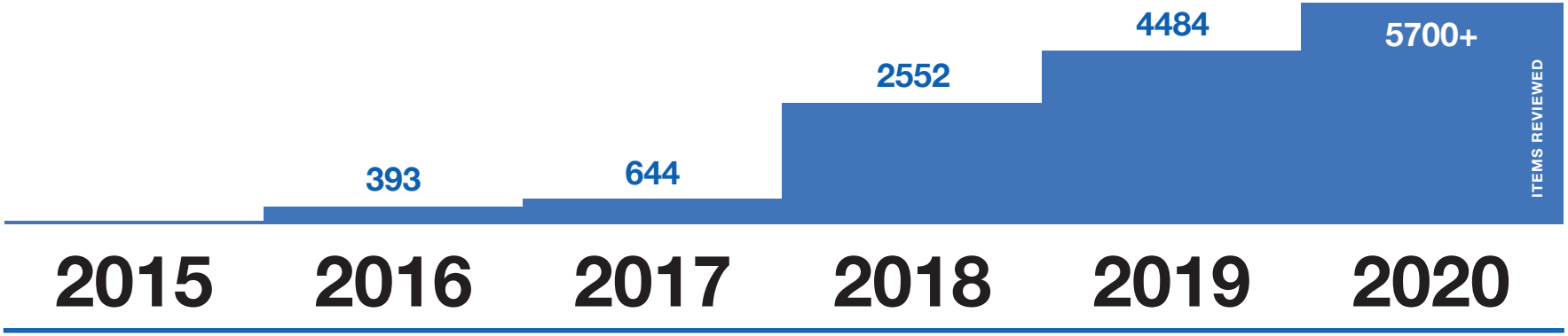
Implementation

Once finalised, the Taskforce reports were provided to Government for consideration. Over the course of the Review, the Taskforce delivered more than 60 reports and 1,400 recommendations across the MBS (see Figure 2). To date, the Government has agreed to implement more than 520 of these recommendations. Some of these key achievements are listed in Figure 3.

Implementation has occurred alongside the process of Review. The Government approved a first round of recommendations as part of the Budget process and began the work of implementation soon after the Taskforce delivered its first reports. Implementation work will continue, with hundreds more recommendations to be considered and introduced.

The process of implementation must continue to be robust and involve individuals and representatives of peak bodies with clinical expertise to help mitigate any unintended consequences or barriers for patients.

Figure 2: Clinical areas and items reviewed



KEY MILESTONES

2015

- Establishment of the MBS Review Taskforce
- Development of process and methodology
- MBS Review Consultation Paper

2016

- Establishment of First Clinical Committees
- Obsolete Items
- Ears, Nose and Throat
- Gastroenterology
- Obstetrics
- Thoracic Medicine
- Interim Report to the Minister for Health

2017

- Principles and Rules Committee First Report
- Urgent After Hours Primary Care
- Dermatology, Allergy and Immunology
- Renal Medicine
- Spinal Surgery

2018

- Endocrinology
- Intensive Care and Emergency Medicine
- Cardiac Services
- Oncology
- Anaesthesia
- Eating Disorders
- DI – Low Back Pain
- DI – Bone Densitometry
- DI – PE/DVT
- DI – Knee Imaging
- DI – Nuclear Medicine
- DI – Breast Imaging
- Neurosurgery and Neurology
- Urology

2019

- Blood Products
- General Surgery
- Plastic and Reconstructive Surgery
- Colorectal
- Diagnostic Medicine
- Gynaecology
- Pathology – Chemical Tests
- Pathology – Microbiology Tests
- Pathology – Genetics Tests
- Pathology – Immunology Tests
- Pathology – Anatomical Cytology Tests
- Pathology – Haematology Tests
- Pathology – Endocrine Tests
- Pain Management
- Thoracic Surgery
- Principles and Rules Committee Second Report to Tasksforce
- Orthopaedics

2020

- Specialist and Consultant Physician Consultations
- Cleft Dental Services
- Ophthalmology
- Optometry
- Otolaryngology Head and Neck
- Paediatric Surgery
- Psychiatry
- Vascular
- Wound Management
- Oral and Maxillofacial Surgery Category 4
- Consumer Panel
- Telehealth
- Primary Care, comprising the recommendations on:
  - Allied Health
  - Mental Health
  - Nurse Practitioners
  - Participating Midwives
  - Aboriginal and Torres Strait Islander Health
  - General Practice and Primary Care
- MBS Review Final Report

DI – Diagnostic Imaging
PE – Pulmonary Embolism
DVT – Deep Vein Thrombosis

Figure 3: Key achievements to date

Over the course of the Review, the Taskforce made over 1,400 recommendations to Government. The Government has acted on the advice of the Taskforce and implemented more than 230 recommendations so far, with many more to be considered and introduced. Some of the Taskforce's key achievements to date are as follows.

OVERARCHING ACHIEVEMENTS

The Government has implemented Taskforce recommendations which ensure greater consistency and clarity across different parts of the MBS, promote better use of evidence to support services funded by the MBS, and have involved high levels of clinical and consumer participation in decisions relating to MBS reimbursement.

AFTERCARE

- Rebates are now paid when a GP provides aftercare to patients following surgery.
- This improves access to aftercare, especially for rural patients who can see their GP locally, but have to travel long distances to see the specialist.

INCREASING REBATES FOR GP PROCEDURES

- Several minor procedures had different item numbers and different patient rebates, depending on who provided the service.
- Rebates for selected minor procedures were increased and the rebate is now based on the procedure, not who performs it.

THORACIC MEDICINE

- Changes will reduce unnecessary testing, improve patient access to high quality MBS funded sleep studies and reduce waiting times for patients who need an attended (laboratory-based) study.
- MBS items for spirometry (a type of lung function test) now include improved quality requirements to encourage well-performed spirometry in general practice. This helps ensure more people are correctly diagnosed with conditions (including asthma and chronic obstructive pulmonary disease) and receive appropriate treatment.

OBSTETRICS

- Private obstetric patients are now supported to receive a mental health assessment during pregnancy and at their six week check-up with their obstetrician or GP. This will help identify and treat anxiety and depression, which research suggests up to 10 per cent of pregnant women and 16 per cent of postnatal women experience.
- Women who choose to give birth as a private patient are supported to spend more time with their provider for the planning and management of their pregnancy through a higher rebate.

GP STEWARDSHIP

- The importance of placing GPs at the centre of patient care has been reflected in the support for introducing the Voluntary Patient Enrolment (VPE) initiative and other actions to enhance GP stewardship.
- VPE would initially focus on older Australians and Aboriginal and Torres Strait Islander patients aged 50 years and older and assess the efficacy of personalised and coordinated care.
- VPE participants enrol with their regular general practice and provide a quarterly payment to their GP of choice, formalising the patient-doctor relationship and increasing patient access and proactive care.

DIAGNOSTIC IMAGING

- Patients now have better access to the latest diagnostic imaging equipment as rebates are now only paid where equipment has not exceeded its effective life age or maximum extended life age, unless the practice has an exemption. This will encourage providers to upgrade their equipment and provide patients with the highest quality of services.
- Two new items allow a breast ultrasound to be immediately followed by an ultrasound-guided intervention (such as a breast biopsy), so patients are no longer distressed or inconvenienced by having to return on another day for a biopsy.

Key achievements to date continued...

EATING DISORDERS SERVICES

- Patients with severely debilitating eating disorders can now access a comprehensive treatment plan under Medicare, including up to 40 psychological services and 20 dietetic services each year.
- This change will likely benefit around 30,000 people each year.

INTENSIVE CARE AND EMERGENCY MEDICINE

- Patient bills are now calculated consistently in private hospital emergency departments (ED), no matter which private hospital they attend, or the specialist they see. Previously, patients were charged differently depending on the individual specialist they saw in a private hospital ED.

KNEE IMAGING

- Changes to knee imaging items prevent unnecessary MRIs and ensure patients are receiving the right tests and treatments.
- Patients under the age of 16 years are no longer required to have an x-ray before accessing an MRI, limiting their exposure to unnecessary radiation.

SPINAL SURGERY

- Evidence showed spinal fusion was not an effective treatment for uncomplicated axial chronic lower back pain, so the rebate for this procedure was deleted to discourage this ineffective practice.

CO-CLAIMING REFORM

- If a procedure fee is more than $300, practitioners can no longer also charge patients a consultation fee. This reflects the expectation that a specialist should consult with the patient as part of more complex procedures. This change reduces overall costs for patients.

URGENT AFTER-HOURS

- Doctors are now required to accurately assess and record the type of care a patient needs when booking an urgent after hours appointment. This helps ensure patients receive the most appropriate care for their needs, such as a hospital visit, a standard after-hours visit or an appointment with their regular GP the next day.
- Inappropriate advertising of services is no longer permitted and rebates have been adjusted to reflect the level of doctors' qualifications.

ENDOCRINOLOGY SERVICES

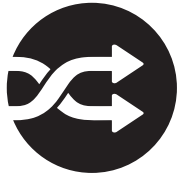
- Patients with an overactive thyroid will benefit from best practice treatment, which is to remove the entire thyroid.
- For providers, changes to parathyroid and adrenal gland surgery items will simplify their use and create consistent billing and treatment practices.

COLONOSCOPY

- There were previously inconsistent approaches to colonoscopies with many patients undergoing colonoscopies unnecessarily. Changes have been made to make it clearer when patients should have a colonoscopy and the appropriate screening intervals.
- This clarity prevents consumers from undergoing unnecessary colonoscopies, which helps cut waiting times and improve access to services for those who need colonoscopies.

DIALYSIS FOR REMOTE AREAS

- A new item enables rural and regional patients to receive life-saving kidney dialysis in their remote communities from nurses, Indigenous practitioners and Indigenous health workers.
- More than 13,800 services have been provided for a total benefit of over $8.2 million as at 30 June 2020.



CHANGES IN PROGRESS

- The Government has also agreed to make changes to items for general surgery, chemotherapy, blood products, urology, neurology, neurosurgery and cardiac imaging to ensure the MBS reflects best clinical practice and provides better health outcomes for patients.

Part One: The context for Medicare – Then and now

Australians expect high quality, affordable and accessible health care. The MBS supports services provided across Australia.

Below is an overview of Medicare, the MBS and a brief history of how health and health care has evolved.

Medicare and the MBS – history and context

Medicare is Australia's publically-funded universal health insurance scheme. It guarantees all Australians (and some overseas visitors) access to a wide range of health and hospital services at low or no cost. It is a key pillar of Australia's universal, world-class health care system and works in partnership with the Pharmaceutical Benefits Scheme (PBS), various joint and state-based public health, community health and preventive services and subsidised private health insurance, to provide the health advice, support and care Australians have come to expect and rely on.

Medicare provides Australian citizens and permanent residents (and some overseas visitors[1]) with:

- medical services such as consultations with general practitioners (GPs) or specialists,
- pathology and diagnostic services,
- free public hospital services via formal agreements with the States and Territories, and
- subsidies for private patients for hospital services.

Australia's first national public insurance scheme, Medibank, was introduced in 1975. It was replaced by Medicare in 1983, a system largely self-funded through a one per cent levy and a rearrangement of existing health insurance subsidies.

Medicare was a major reform at the time. It established a public health benefits system built around three key principles to be: 'simple, fair and affordable' (3).

Nearly four decades later it is important to remind ourselves of the reform's original intent. The following is summarised from the public policies as they were presented between 1973 and 1984[2] (2) (4).

- Social equity – The scheme is to be equitably financed based on an individual's capacity to pay linked to their income. This is achieved via the Medicare levy and Australia's progressive income tax system.
- Universal coverage – Universality of coverage and eligibility of the scheme for all.
- Cost efficiency – The Government has a duty to ensure taxpayers get the best value for the health services they pay for. This extends to a duty to see that money is not wasted on an inefficient system of health insurance and the maximum number of health dollars are spent on delivering services rather than administering the system.

For further information about the history of health insurance in Australia, see the table at Appendix 2.

The MBS is a list of the medical services for which the Government provides a Medicare rebate, to provide patients with financial assistance towards the costs of the medical services.

1 Australia has *Reciprocal Health Care Agreements* with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy, Malta, Belgium and Slovenia. Visitors from these countries are entitled to medically necessary treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the PBS.

2 Medibank in 1973, presented to the public in the 1983 Federal Election campaign as the 'Hayden Health Plan', and in Medicare in 1984.

The MBS sets out the 'schedule fee' for each service to determine the amount of the patient rebate. The rebates are paid as a percentage of the schedule fee, as follows:

- 100 per cent of the schedule fee for GP consultations
- 85 per cent of the schedule fee for all other services provided by a medical practitioner in the community
- 75 per cent of the schedule fee for all in-hospital services provided by medical practitioners to private patients

Patient rebates are provided for the following services:

- consultation fees for GPs and specialists
- diagnostic tests and procedures, which are medical services needed to treat illnesses, including diagnostic imaging and pathology tests
- most surgical and other therapeutic procedures
- eye tests performed by optometrists
- some surgical procedures performed by approved dentists and specified dental care services for eligible children
- specified items under the Cleft Lip and Palate Scheme
- specified allied healthcare services for chronically ill people who are managed by their GP

The schedule fee is a fee-for-service set by the Government and may differ from the medical professional's actual fee, which they are free to determine. If the practitioner chooses to accept a fee equal to the MBS rebate, the patient can assign that rebate from the Government to the practitioner as full payment of that fee. When this is offered to one or more patients it is referred to as 'bulk billing'. If the practitioner charges a fee that is higher than the rebate, the patient must pay the full cost of the service before claiming the rebate from the Government. The gap between the fee and the patient-rebate is borne by the consumer as an 'out-of-pocket' (OOP) cost.

The Government provides a 'safety net' to assist patients with these out-of-pocket costs through the Original Medicare Safety Net (OMSN), introduced in 1984, and the Extended Medicare Safety Net (EMSN), introduced in 2004 (5).

Under the safety net arrangements, patients who spend a certain amount on doctor and specialist visits in a calendar year, and reach certain thresholds, are entitled to higher Medicare rebates for any future out-of-hospital Medicare services for the rest of that year.

Under the OMSN, a patient receives 100 percent of the schedule fee, rather than 75 or 80 per cent, once the patient has spent the threshold amount (this threshold amount is calculated using the 'gap' amount between the MBS rebate and the MBS schedule fee, not the total fees paid by the patient)[3].

Under the EMSN, a patient receives additional payments to help them with their out of pocket costs. The EMSN pays 80 percent of a consumer's OOP costs once the patient has spent the threshold amount. For the EMSN, the threshold is calculated using the OOP costs incurred, being the difference between the MBS rebate and the doctors' or specialists' total fee.

There are separate thresholds for individuals, families and concession card holders, and certain limits apply[4] (5). There also is an upper limit on the amount of benefit that can be paid under the EMSN for a small number of Medicare services.

3 In 2020 the threshold for the OMSN is $477.90.

4 Extended Medicare Safety Net (EMSN) thresholds 2020:
- $692.20 for Commonwealth Concession Cardholders, including those with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card and people who are eligible for Family Tax Benefit Part A
- $2,169.20 for all other singles and families

Patient choice is a well-accepted principle under Medicare. Individuals are free to choose their GP, restricted only by availability. However, a referral from a GP is required before consulting a specialist practitioner under the MBS. Patients may consult more than one GP, and can also exert a choice over the referral made by their GP to a specialist or to a hospital.

Each professional service in the MBS has been allocated a unique item number, as well as an item descriptor, which outlines the service requirements. Certain items also include explanatory notes to provide practitioners with additional detail on the service requirements and the range of treatments and/or assessments that should be provided to meet the requirements for billing a service. These descriptors and explanatory notes provide support for practitioners, and enable auditing and system integrity checks to be undertaken.

How health and care have changed

As a nation, we can be proud of our general good health (6) and the fact we are supported by a health care system that rates so highly internationally. Australia's health care system is regarded as one of the top performers, with international comparison revealing outstanding health care outcomes and delivery of value for money (7). Medicare has played a major role in enabling Australians to access high quality care.

Although our health outcomes have improved under Medicare, sections of our population, especially Indigenous Australians, still require more timely access to appropriate care. We are living longer, and ageing as a population. Since the inception of the MBS in 1984, the life expectancy at birth for women and men has increased from 79 to 85, and 72 to 80 years respectively (8). We face growing risks to our long-term health, and the nature of care needs to change to ensure we can continue improving our health and wellbeing into the future.

When the MBS was created, the predominant need was for episodic care of acute medical and surgical problems. There has been a huge shift to longitudinal care of multi-morbidities including mental health. Many patients routinely require complex integrated care over time and across multiple providers.

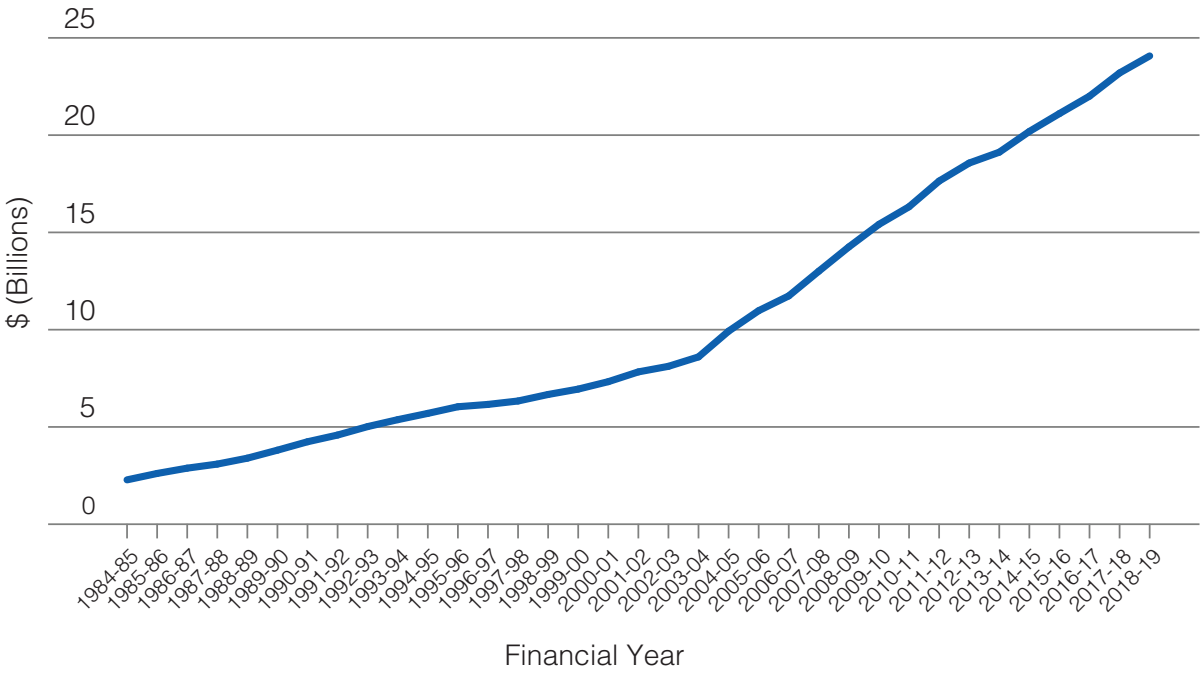
Based on current risk factor trends (9), it is reasonable to assume more resources and increased expenditure will be required to treat chronic disease into the future, or the health system will need to adapt to provide more effective, coordinated care.

The MBS has served Australia well and will continue to do so. However, Australia's health requirements have changed as we live longer and our needs have become more complex, so the structures of the health system must continue to adapt. Increasing use of new technologies to identify and treat disease, coupled with greater consumer engagement and a growing economic imperative to shift care away from hospital settings means the health system must modernise and evolve beyond the one dimensional fee-for-service model of the MBS.

Financial sustainability of the MBS

Although Australia's health system rates well domestically and internationally, its future fiscal sustainability is frequently debated through health policy, by the media and in academia. Health funding across the system has consistently increased, and the MBS is no exception. Since 1984, Australia has experienced year-on-year increases in MBS spending. In the past five years, MBS expenditure has increased from $20.2 billion in 2014-15 to $24.1 billion in 2018-19 (Figure 4) (10), and is projected to reach $31 billion per annum from 2022-23 (1).

Figure 4: MBS Expenditure 1984–85 to 2018–19



Analysis by the Parliamentary Budget Office (11) in 2015 identified the increase in MBS expenditure between 2003-04 and 2014-15 was mainly driven by policy changes that broadened the scope of services covered by the MBS or increased the benefits payable for eligible existing services, including the introduction of the EMSN in 2003–04.

These policy changes largely impacted three broad service areas including:

- GPs:
  - GP rebate increased from 85 per cent to 100 per cent of the Schedule Fee in 2004–05,
  - Introduction of bulk billing incentives,
  - After-hours GP items and new multidisciplinary care plan items,
  - Changes to the rules relating to migrant GPs, and
  - The opening of new medical schools, increasing the availability of services.
- Allied health - addition of a wide range of allied health services such as physiotherapy and mental healthcare.
- Pathology and diagnostics:
  - Introduction of a range of Computed Tomography (CT) items in 1996–97, and
  - Magnetic Resonance Imaging items added in 1998–99.

These policy changes have undoubtedly benefited consumers, but as the MBS is an uncapped, demand driven fee-for-service program, any expansion of coverage directly impacts the cost to the taxpayer.

The Taskforce also noted that efforts by public hospitals to privatise outpatient services, including a range of diagnostic services such as x-rays, along with the growth of private inpatient numbers, has resulted in the care for those patients being funded by the MBS, not the hospitals. This cost shifting by public hospitals is a significant driver of increased costs of the MBS.

MBS expenditure is expected to continue to increase as the population ages, and demand for services heightens. The ageing of the baby boomer generation and the increasing prevalence of people living with chronic and complex health problems will likely see the disease burden, and demand for care, increase in coming years. Increased incomes will continue to raise consumer expectations of the system to meet healthcare needs. Further, technological innovations such as personalised medicine, stem cell research, and genomics have the potential to significantly change care and, while likely increase some costs, may lead to more targeted, cost effective interventions.

Further information about common drivers of healthcare need and expenditure is at Appendix 3.

Where to next?

The design of universal healthcare in Australia was determined largely by the continued tension between a universal healthcare provider system versus a universal healthcare funding system. Medicare was designed to finance access to the health system, not how the healthcare system could better deliver services to the community (12). Close to four decades later, it is a significant challenge to engineer the funding system (i.e. the MBS) to drive the necessary changes in the healthcare provider system. This approach has its limitations.

There is a growing need for the MBS to continue to adapt to ensure patients and taxpayers receive greater value for their investment in the health system. Implementing changes to the MBS as financial incentives to drive changes in the behaviour of providers is possible.

The Taskforce believes changes made to the MBS in the future should continue to support the original principles of Medicare. The Taskforce also acknowledges the MBS fee-for-service model is not the only way to fund services, and alternative funding models should complement the MBS in healthcare delivery.

The Taskforce explored the role of the MBS as a key pillar of the healthcare system. Medicare and the MBS can and must improve. The MBS requires continual, rigorous and comprehensive review and analysis, and a continuous review mechanism should be established for this purpose. This will ensure the MBS can adapt to meet Australia's changing healthcare needs and that the significant and growing investment in the MBS delivers value for funders and for patients.

Part Two: Opportunities and challenges to strengthen the MBS

Over the course of the Review, the Taskforce and its clinical committees have been able to observe the MBS and the issues within its operation. With the benefit of five years' observation, the Taskforce can now make comment on some of the broader opportunities and challenges for the advancement of patient care and the future sustainability of the MBS. These are presented as six key themes:

- Creating an MBS that meets the needs of consumers

  This section details the importance of placing the consumer at the centre of any assessment of the system, noting the system should recognise and be responsive to their needs as its first priority. It cites the benefits and need for consumer involvement in any future review of the MBS, describes processes to achieve this, and makes recommendations to address consumer concerns about the costs of care and informed decision making.

- Improved measurement of healthcare for consumers

  Better data and information, particularly on the quality of care, is crucial to evaluating and investing in high value healthcare, and to ensuring MBS-funded services are fit-for-purpose and used appropriately. The Taskforce has made recommendations to enhance patient-level decision making, resource planning and allocation and drive improvements in clinical care and patient outcomes.

- Alternative funding models to support healthcare delivery

  The Taskforce has recognised how health needs and care delivery have changed since the introduction of the MBS almost 40 years ago. It recommends the MBS fee-for-service model should be complemented by alternative funding models to encourage more efficient, coordinated care with a greater focus on preventative health and better management of chronic conditions to deliver better outcomes for patients.

- GP stewardship within the healthcare system

  The Taskforce supports the pivotal role of GP stewardship in delivering holistic, longitudinal and patient-centred care in the community. The section outlines recommendations to better support GPs in this role, trial different approaches, and improve and measure patient outcomes.

- Harnessing innovation to deliver contemporary care

  It is clear the potential of technological advances need a robust and clear system to deliver improvements for consumers. This section assesses that potential and maps a path to drive and improve research, evaluation and delivery of innovations in healthcare for all consumers.

- Consistency across surgical procedures

  Many of the Taskforce's clinical committees encountered similar issues and the Taskforce's principles and recommendations will improve consistency and quality across the MBS for providers and patients. These reforms will support the MBS to deliver high value, quality care.

These themes are expanded below with the issues first being described and analysed and then a concluding recommendation provided.

Creating an MBS that meets the needs of consumers

The Taskforce reviewed the MBS with a focus on consumers, envisioning a system responsive to their needs and able to support an appropriate level of care. In undertaking the Review, the Taskforce identified a number of consumer care issues that were not item specific but emerged across the MBS.

These issues related to:

- The lack of a defined and consistent framework to support a consumer focused system of healthcare delivery
- Concerns about costs of care outside the public hospital system, and the need for more accessible information on costs and options for treatment
- Barriers to care including geography, social disadvantage, the relationship between public and private sectors, and the provision of culturally appropriate care

Issue: A consumer focused framework

To ensure that consumers were placed at the centre of the Review, the Taskforce and its clinical committees developed and introduced processes and approaches for ongoing collaboration with consumers, including:

- Involving informed consumers from the very beginning
- Consulting and engaging with consumers and stakeholder groups to formulate the methodology and process for the Review, identify priority areas for action, and develop recommendations
- Including consumer impact statements and specifically tailored summaries in each report to help consumers assess the impacts of recommendations
- Ensuring additional consideration was given to Aboriginal and Torres Strait Islander issues (e.g. consideration of whether services were culturally safe and appropriate)
- Consulting with consumer and stakeholders on clinical committee and reference group recommendations, considering the feedback and addressing any concerns before finalising recommendations
- Holding forums and webinars to engage with consumer stakeholder groups throughout the process
- Appointing consumer representatives to individual clinical committees and working groups to provide advice and input into reports
- Establishing the Consumer Panel to provide an independent consumer perspective on the Review process and support the work of consumers

These approaches provided guidance to clinical committees and the Taskforce on how a consumer centric process could be applied and ensure any further similar reviews would have the same focus.

Consumer representatives on clinical committees, working with their clinical colleagues, were encouraged to apply a series of questions to assess items and proposals for change. This assisted the consumer representative on clinical committees and working groups to help safeguard and promote the consumer voice. This approach was also a timely reminder that the health system is primarily about service to consumers.

The below outlines the types of questions applied during clinical committee reviews.

Examples of Questions to Focus Consumer Perspectives

When reviewing recommendations to change or delete MBS items, the consumer representative considered the following questions:

- Would there be a positive or negative impact on safety?
- Would there be a positive or negative impact on the quality of services provided?
- Would there be any limitations on access, particularly for people living in rural and remote locations or people with special needs, including Aboriginal and Torres Strait Islander people?
- Would the efficacy of the test or treatment (or sometimes a series of tests or treatments) be reduced or increased?
- Would the changes reduce or increase cost-effectiveness or future costs, and was there the potential for a perverse outcome?
- Would the change increase accountability by providing conditions against which service providers could be measured?
- Would the change increase data collection for research, monitoring and audit purposes?

The Consumer Panel reflected on the experience of its members working on the MBS Review and developed a set of recommendations to ensure the MBS continues to place consumers at its centre. These are included in the Consumer Panel Final Report.

It provided clear guidance on how future deliberations and decisions on the listing of new health technologies, and any ongoing cycle of MBS Review, should include consumers:

- Apply the Consumer Panel's list of Principles which cover safety, quality, equity, and access and system responsiveness
- Use the Consumer Engagement Resource to guide public consultations and inform consumer recruitment, induction and support
- Consider the consumer priorities as key drivers in future review
- Continue a genuine, evidence-informed partnership between consumers, clinicians, researchers and policy-makers.

Despite the achievements in including patient considerations in the Review, involving patients in their care remains an ongoing challenge. Meaningful consumer engagement will need to evolve if it is to deliver improved patient outcomes.

Recommendation 1

Ensure all future reviews require consumer input and use a consumer framework to enable a consistent and consumer focused approach.

Issue: Concerns about costs of care outside the public hospital system

Throughout the Review, consumers raised issues around costs for treatment outside the public hospital system. In particular these issues related to:

- Out of pocket (OOP) costs
- Transparency of costs and informed financial consent.

Out of pocket costs

When accessing healthcare outside the public hospital system, most Australians experience OOP costs. OOP costs for consumers in the community setting is the difference between the practitioner fee and the MBS rebate. OOP costs for consumers in the private hospital setting is the difference between the MBS rebate together with the health insurer contribution and the fee set by the practitioner.

A 2018 survey by the Consumers Health Forum of Australia found that one in six people undergoing cancer treatment were placed under an unreasonable financial burden through OOP costs, with some even needing to draw down on their superannuation to pay for the care (13). It is also noted where services have been corporatised, OOP costs may be particularly onerous. An example of this is invitro-fertilisation (IVF) which has been largely corporatised, so patients face significant out of pocket costs. The first cycle of IVF in Australia is estimated to have OOP costs ranging from approximately $4800 (14) to $5100 (15). This does not include the cost of fees associated with diagnosing infertility, or the medications required. The emotional toll of treatment, including the pressure of potential failure or the joy of success, leaves few feeling able to complain about the expense.

According to the Australian Institute of Health and Welfare (AIHW), the contribution by individuals to total health spending reached $30.6 billion in 2017-18. This increasing burden on patients may lead to some individuals avoiding care. Often, they may be the most in need. Delaying or foregoing care means when they do visit their doctor, their condition may be much worse than if they had presented earlier. This can affect long-term health outcomes and lead to higher costs over time.

Consumers frequently choose to receive private care, with no real understanding of the possible costs and little time or knowledge to compare providers or costs.

Consumers are concerned about the magnitude of OOPs as well as the process of billing. Consumers often indicate that they are distressed by multiple invoices from several providers including consultations, procedures and diagnostic tests. They are unsure when the final invoice will arrive and often they are unaware that they will be invoiced by some providers, such as surgical assistants. This causes considerable uncertainty and stress when they are at their most vulnerable.

Although some degree of OOP costs has always been an issue, their increasing magnitude has led to greater impact on consumers and their families. There are several reasons for the size and variability of OOPs, including limited MBS indexation, burgeoning technology, more complex treatment regimens, ageing population and chronic disease and doctor behaviour.

The Taskforce notes that the MBS is limited in its ability, through rebates, to influence consumer related healthcare expenses, as practitioners are legally able to set their fees unrelated to the MBS schedule. While Taskforce recommendations focused primarily on providing clinical advice on services, it also, on occasion, made recommendations to address inappropriate rebates. In some cases, this meant recommending reductions, but in other areas the Taskforce made recommendations to increase rebates.

For example, following Taskforce advice, the Government increased the rebate for selected minor procedures performed by GPs, so that the GP rebates are aligned with specialist rebates, and benefits are provided on the basis of the procedure and not the practitioner who performs it.

A number of options are available to reduce consumer OOPs which include but are not limited to Medicare Safety Nets, which have been in place for some time with further changes under consideration (see below), or actions outside the MBS which do not lower the quality of care. The Taskforce noted the work undertaken by the Ministerial Advisory Committee on Out of Pocket Costs to inform this work.

Extended Medicare Safety Net (EMSN)

The EMSN was introduced in 2004 to make medical services more affordable for those with high out-of-pocket (OOP) costs particularly those with complex and high healthcare needs. The EMSN pays up to 80 per cent of out-of-hospital OOP costs once a threshold has been reached in a calendar year.

There is strong evidence (16) the EMSN is not meeting its original objectives and has led to a number of unintended and negative consequences. Recent analysis of the EMSN shows:

- The EMSN may incentivise providers to alter consumer billing practices and increase fees to reach EMSN thresholds. Some providers are inflating fees with the understanding the EMSN will cover 80 per cent of consumer OOP costs once they reach the threshold.
- Significant expenditure goes towards consumers who visit very high fee charging providers. In 2018, of the 209 MBS items analysed, 47 per cent of benefits were for services provided by the top 10 per cent most expensive providers and 79 per cent of benefits to the top 30 per cent of providers.
- EMSN expenditure is distributed towards consumers residing in wealthier and metropolitan areas of Australia and does not effectively reduce cost pressures on those in most financial need. In 2018:
  - 83 per cent of EMSN benefits were received by people living in major cities
  - 42 per cent of benefits went to the top 20 per cent of Socio-Economic Indexes for Areas (SEIFA)
  - The bottom 20 per cent of SEIFA incurred 10 per cent of total OOP costs but received only 7.7 per cent of EMSN benefits
  - The top 20 per cent of SEIFA incurred 35 per cent of OOP costs but received 42 per cent of EMSN benefits
- Research has shown previous reforms have had a substantial impact on overall EMSN expenditure, the expenditure of capped items and the fees charged by doctors. The 2011 Review of EMSN capping arrangements (17) found expenditure fell by $226.8 million in 2010 compared to 2009. There is also some evidence the caps led to providers reducing their fees for services provided out of hospital, particularly high-charging ones. There is also evidence of practitioners changing billing practices by shifting from capped items to non-capped items.

Recommendation 2

Establish a Working Group with the medical profession and consumers to:

1. further investigate and provide advice to Government on the current issues with EMSN policy, and
2. identify options to address these issues so that the EMSN can better meet its original intent.

Transparency of costs and informed financial consent

Consumers often find the fees and treatment plans proposed by their healthcare professionals confusing and complex. At times, these are not well explained and the ongoing invoices received from a variety of practitioners can cause considerable stress.

While many practitioners charge reasonable and proportionate fees and take steps to disclose the relevant costs of treatment and charges to consumers, a more consistent process is needed to improve transparency and understanding of costs before treatment commences. This will support consumer decision-making, and empowerment to negotiate on fees if necessary. In

addition, sharing cost information may encourage some providers to reduce their fees through competition.

The Government has made progress in improving transparency of healthcare costs for consumers through two recent initiatives, the 'Medical Cost Finder' website and reforms to simplify and streamline private health insurance.

Over the last five years, the Taskforce has proposed changes that will intend to impact on charging practices, and deliver further transparency for consumers through the MBS. For example, the Taskforce's PARC has recommended a working group be formed to address key concerns relating to the MBS remuneration arrangements for surgical assistant services. These included:

- separate billing of the consumer by the surgeon and assistant, and the surgeon's frequent lack of visibility of their assistant's billing practices
- wide variability in the amounts of OOP costs charged by assistants, including instances where the assistant charged a higher fee than the surgeon.

At the time of this report, Government is still considering this recommendation.

Another example includes the Taskforce work to develop a guiding principle on informed financial consent. This stated "in a consumer led healthcare market, consumers need clear and transparent information to give their full informed consent on services". The Taskforce also noted its support for the Ministerial Advisory Group's work on OOP costs.

Currently, informed financial consent is mandated only when being admitted to a private hospital (18). This requires the hospital to inform a consumer or nominee, in writing, of what hospital charges, insurer benefits and outofpocket costs (where applicable) are expected in respect of the particular hospital treatment at that time.

There are currently no consistent, enforceable guidelines requiring all healthcare providers to give cost related information. The Commonwealth Ombudsman's website provides guidelines on informed financial consent in healthcare:

> *'You should ask your doctor, your health fund, and your hospital about any extra money you may have to pay out of your own pocket, commonly known as a "gap" payment.'*

These guidelines currently place the onus on the consumer who is disadvantaged in these discussions due to their unequal knowledge base.

The Taskforce recommends all financial information provided to consumers be documented and provided with a cooling off period before treatment is commenced. This documentation must include information on the right of consumers to seek a second opinion for treatment and costs.

Recommendation 3

Develop and mandate a consistent documented procedure with appropriate provision of information to assist providers in explaining costs to consumers prior to a course of treatment.

Issue: Informed consumer choice and treatment consent

Beyond costs information, consumers also need details of their diagnosis, options for treatment (including no treatment) and associated benefits, harms, and uncertainties. This transparency gives consumers greater control over their treatment and enables people to make choices that meet their needs and preferences. Consumers should be made aware that in many cases treatment plans are often a multidisciplinary approach.

The Taskforce drew on the work of the the Specialist and Consultant Physician Consultation Clinical Committee, which acknowledged that "it is ultimately the consumer who manages their overall health and wellbeing and the consequences of any decisions made about their care, and so it logically follows that consumers should participate in decision-making to the degree they are willing and able. It is incumbent on clinicians to support health literacy and engagement by creating care environments where people can actively participate in and agree on healthcare decisions that affect them".

If patients have access to clear and comprehensive information, it will help them to engage with the clinician in a shared decision-making process. The onus must be on the clinicians, in partnership with consumers, to empower consumers to make informed choices. This should be done by providing accessible and easily understood information as part of the service provided.

Considerable work has been done in the public hospital system to improve consent processes including simplified documentation, availability of information both hard copy and audio-visual, and auditing systems for continuing improvement. Such systems could provide the basis for improvements for the information provided by healthcare professionals outside the public hospital system.

Recommendation 4

Develop clear and consistent systems and processes to better support consumers to gain a comprehensive understanding of their diagnosis, options for treatment and risks and benefits.

Issue: Grievances about medical fees

The process to raise grievances about medical fees can be extremely complex and daunting for consumers. Under the current system, if a consumer disagrees or has a concern with a medical practitioner's charges, the advice of the Commonwealth Ombudsman is to first (19):

> *'Check that you didn't agree to these charges before treatment. If you were told about the charges in advance and did not question them at the time, you may have implicitly agreed to pay the fee. Contact your doctor or doctor's office staff to discuss the reasons for the various charges and why they are more than you expected.'*

In some instances, the Private Health Insurance Ombudsman (PHI Ombudsman) may be able to assist consumers in these areas. However, many situations are beyond the remit of the PHI Ombudsman, including any services provided as out of hospital medical services, such as visiting your doctor or specialist in their rooms, or having radiology or pathology tests. In these circumstances, consumers will need to seek assistance from their state or territory health complaints agency.

These processes can be time consuming and difficult to navigate, especially if there are visits to different practitioners at different sites of care. It is likely that the consumer would also be trying to manage their illness whilst seeking assistance from the relevant ombudsman or complaints agency.

A single, independent medical fee complaints tribunal could reduce these pressures on consumers and with appropriate safeguards provide greater public transparency over unwarranted or high outofpocket costs. It is proposed this tribunal deals with the complaints of individual consumers about their specific course of treatment, rather than being a forum for professional groups to raise their issues with fees.

The tribunal could comprise a consumer and members from peak medical bodies on a rotating or co-opted basis as relevant. Where complaints are brought to the tribunal, members would be required to make a finding about what a reasonable fee should have been. This tribunal could leverage existing processes, practices and resources that may exist within the Commonwealth and PHI Ombudsman, as well as health complaints agencies. Leveraging existing processes would help mitigate the duplication of functions across entities. It would be very useful for the tribunal to report annually and provide a publicly available account of fee setting trends and OOP practices.

Precedent for a similar, but binding, function exists in New South Wales (NSW) for disputing legal bills. The Office of the Legal Services Commissioner (OLSC) deals with a range of complaints, including legal bills issued by solicitors and barristers acting in NSW, and if a client cannot resolve a cost dispute directly with their lawyer, the OLSC offers a costs dispute resolution service at no charge. The Commissioner has the power, in appropriate cases, to make a determination about costs, including a binding determination specifying the amount payable.

Recommendation 5

Establish a Medical Fee Complaints Tribunal to act as a formal and independent mechanism for individual consumers to have fee concerns reviewed.

Issue: Barriers to care

Complex systems level barriers, social disadvantage, geography and cultural factors mean consumers sometimes fall through the gaps and have difficulty accessing care.

Remoteness is a clear example where options for care are limited for consumers. There may be no local, accessible public services, with expensive private services the only alternative. These may be delivered by practitioners temporarily visiting from metropolitan areas, which impacts on continuity of care or follow up. Consumers may have to choose between long waiting lists for public hospital services, or high out of pocket costs in the private sector. Cultural factors, age and health status can also make it hard for consumers to navigate through the health system.

The Review identified and, where possible, responded to specific access gaps. Examples include the introduction of new services for eating disorders, access to renal dialysis in remote areas, flexible access arrangements through patient enrolment with general practice, and recommending access to some ophthalmological procedures by enhancing workforce diversity (such as has occurred overseas and notably in New Zealand).

In other cases, policy solutions may need to be developed that are outside the fee-for-service model that is the MBS. The Taskforce reflects considerations on this issue in Recommendation 11 of this Report.

Improved measurement of healthcare for consumers

Introduction

The MBS Review Taskforce was established with the clear purpose of identifying and supporting high-value care that meets the needs of the Australian community.

Over the course of the Review, the Taskforce became increasingly aware of the need for better data and information to help inform decisions about effectively investing in patient care at the regional and national level. The Review also highlighted the importance of making information available to help practitioners to reflect and improve on their own practice, and to enable quality assurance and safety across not just the MBS, but the entire health system.

Over the past decade, Australians spent approximately $1.6 trillion on healthcare. Conservative estimates predict we will spend another $2.0 trillion in the coming decade[5] (20). Given this significant investment, it is critical that services delivered are of high value.

Defining value

A central tenet of the MBS Review has been to ensure the MBS subsidises high value care. Care should be essential, cost effective and prioritise patient needs.

What is value?

Value is critical to supporting the delivery of effective healthcare. While value is often associated with the notion of cost and investment, value includes the health outcomes for a patient, through the provision of effective, high-quality and safe care that meets their needs (21).

This is an important distinction in the provision of health services. There will always be differential cost-inputs to the system depending on the type of intervention needed to improve a patient outcome. If these are considered in isolation to the value a service delivers, it can cause imbalances in the effective and efficient resourcing of health services.

Expenditure accountability

Historically, when attempts are made to improve the sustainability of a health system, it is generally assumed existing care is already of high quality, all services are necessary, and outcomes required by consumers are being met. Efficiencies are often aimed at reducing the cost of services to curb expenditure. In fee-for-service models like the MBS, the sector generally counters reductions in revenue by either increasing costs for the patient or increasing volume. Consequently, the system rewards increased volume or cost instead of driving sustainability or positive outcomes for consumers.

The MBS provides a patient rebate to consumers for clinically relevant services provided by a healthcare practitioner. This means subsidies are paid for services rendered, regardless of the outcome or the quality of care provided under the item number claimed. Without any means to systematically measure the value gained from the intervention, consumers and taxpayers must rely on medical professionals to act according to best evidence and in the consumer's best interests.

Integrity and appropriate use

As a critical accountability mechanism, the Government manages an audit and compliance function to support funding integrity. This function works to detect and prevent incorrect claiming, inappropriate practice, and fraud by healthcare providers and suppliers. The Government also

5 In constant dollars using the average annual real growth rate of 3.9 per cent over the decade to 2017–18.

provides educational material and policy guidance on the claiming of MBS items. The issue of non-compliance was raised several times during the course of the review with members across many clinical committees and working groups supporting an ongoing and expanded role for a robust integrity assurance function.

The Government's *Professional Services Review (PSR)* Agency already exists to protect patients and the community from the risks associated with inappropriate healthcare practices. Inappropriate practice is defined as:

> *"Conduct by a practitioner in connection with rendering or initiating services that a practitioner's peers could reasonably conclude was unacceptable to the general body of their profession." (22)*

The Taskforce acknowledges the need for compliance and supports this through an increased focus on clarifying item descriptors and recommending increased education and support for providers.

Low-value care

While the above mechanisms are effective in delivering accountability and protecting inappropriate health practices, it does not capture all types of low value care by focusing solely on compliance with the intent of the item descriptor. It is possible to be technically compliant but not provide high value, appropriate care.

As an example, the Taskforce examined the use of item 22018, which provided a rebate for monitoring lung and/or ventilator function through arterial blood gas measurement for a patient under anaesthetic. High levels of use for item 22018 were noted, with service growth exceeding population growth by a considerable margin. As monitoring and adjusting ventilation is standard clinical practice, and in some instances occurs without arterial blood gas measurement, this item was removed from the MBS as it was effectively redundant. Its removal also discourages unnecessary insertion of arterial cannulas which is not without risk to the patient.

Another example includes changes to MBS-funded spinal X-rays and who can request them, following recommendations from the Taskforce. Evidence indicates that routine imaging of the back by whole spine X-rays (three and four regions) is not associated clinical benefit and can lead to unnecessary doses of radiation. Most presentations of back pain do not require diagnostic imaging, as the result of any imaging is unlikely to change clinical management. The Government has removed the ability of chiropractors to request whole spine x-rays, as chiropractors order the majority of these services.

Towards a standardised, best practice model of formulating MBS items

The MBS Review revealed substantial variation in approaches to the description of items. To an extent this is understandable given the evolution of the MBS over time, and that many services had not been reviewed since their inception. The Taskforce noted that some items only described the service, others included the condition, others the service with some reference to a condition. Some included notes regarding appropriate frequencies of service while others did not. Item descriptors were inconsistent, with differing levels of detail and requirements. This can be confusing for providers and may lead to difficulties in maintaining system integrity.

The Taskforce supports the recent shift by MSAC to a model of including as much detail as reasonably possible when it is constructing items, both in terms of the item descriptors and the accompanying explanatory notes.

The MSAC evidence-based review process and accompanying clinical engagements provides significant detail for the Appropriate Use Criteria of items. These criteria are derived from the evidence base. It was recognised early by the Taskforce there are parallels with the MBS Review

process, hence it was an opportune time to align with MSAC's current best practice. This would give rigour to the process which is not only important from a governance perspective (e.g. transparency of method) but would assist the various Committees in their work of reviewing and re-constructing items. It also offers a degree of consistency in approach. Furthermore, given the recommendation for a continuous review, this would commence a formalised methodological approach that can be evaluated and modified over time to be increasingly fit-for-purpose. Finally, it was considered this approach would educate the clinical and general community about appropriate item use and bolster the educational and system integrity functions of the PSR, Services Australia, and other agencies within government.

The Taskforce conceded that it may not be possible, necessary or desirable for some items under review to receive such stringent attention – however, that a best practice principle be adopted to support its work and that of the sub committees. The basic principle is that the descriptors give evidence-based clinical guidance, and set practice expectations and benchmarks while allowing for exceptions. In their deliberations, committees considered a range of factors when deliberating on item changes, including:

- Schedule fee
- Consumer requirements: Age (e.g. adult vs paediatric)
- Intervals of services/recommended frequency
- Sequence/place in clinical pathway
- Co-claiming restrictions
- Where should the MBS items services be performed: in-hospital and out-of-hospital services?
- Who can provide service: Eligibility of providers (GP/specialist/training required)/On behalf of?
- Items consolidation: Can items that describe the same service be consolidated?
- Unbundling of services: Can items that describe more than one service be separated?
- New/amend item descriptors and notes:
  - Better describe the service
  - Better target consumer groups who will benefit from the service
  - Is it a 'clinically relevant' service?
  - Limit frequency of use
  - Limit use to inpatient or outpatient settings

Recommendation 6

Ensure the proposed Continuous Review of the MBS described in Part Three includes audit, integrity and appropriate use monitoring.

Issue: Provider education in MBS rules and processes

The Taskforce noted many providers have limited awareness of the rules and procedures involved in billing for MBS services, and may adopt questionable practices on the advice of colleagues. The issue is also explored in the GP stewardship section of this report, with the recommendation to expand the use of clinical decision support tools at the point of care to integrate MBS item descriptors and support appropriate use of health services.

The Government provides a range of screen reader and interactive provider education modules to educate providers in the use of the MBS (23), but there is currently no compulsion for providers to consult this resource and many are unaware of its existence.

The PARC noted the range and quality of these education resources and agreed on the value of such education in promoting efficient and appropriate practices and as a means of impressing providers with an appreciation of the responsibilities attached to access to public funding through the MBS. The Taskforce agrees the satisfactory completion of an online assessment in MBS rules and processes should be a prerequisite for the granting of a MBS provider number.

The proposal, if implemented, would involve a modest additional impost on providers. However, there would be significant potential benefits in terms of more efficient practice administration, and a reduced risk of incurring penalties (for example, the repayment of improperly paid benefits) from breaching compliance with MBS billing requirements.

In principle, a provider of MBS services, having the access to public funding their eligibility entails, has an obligation to acquire knowledge of MBS rules and billing requirements adequate to ensure their compliance with those rules and requirements as they apply to the provider's practice.

Recommendation 7

Develop and implement a mandatory requirement for providers to complete training / online assessment prior to approval for an MBS provider number to ensure all providers have a comprehensive understanding of the MBS.

Issue: Outcome data limitations

In Australia, very little data exists on the quality of care in the outpatient setting. Vast amounts of activity specific data is generated and collected, but the majority relates to activity that is, the goods and services received or performed, which patients received them, who provided them and at what cost. From an investment standpoint this is useful information, but it is also important to consider the impacts or effects of these services. Meaningful information and analysis on the outcomes and quality of services is needed to ensure high value care is being delivered.

The Taskforce notes progress is being made in Australia to seek to monitor and inform both the quality and effectiveness of services being delivered to patients.

For example, work is being undertaken to support a National Clinical Quality Registry (CQRs) Strategy to maximise the potential of Australian CQRs. CQRs monitor the quality (appropriateness and effectiveness) of healthcare within specific clinical domains by routinely collecting and analysing clinical performance data and providing continuous, risk-adjusted, benchmarked feedback on clinical practice and patient outcomes, to improve the standard of care.

Example 1: Prostate Cancer Outcome Registry-Victoria (PCOR-Vic) (24) (25)

The PCOR-Vic, managed by Monash University, systematically follows up with men after a diagnosis of prostate cancer and provides regular, benchmarked feedback to clinicians and hospitals on the patterns of care provided in public and private Victorian hospitals, variations in care and health related quality of life and survival outcomes. The PCOR-Vic has had a significant impact on treatment variation and outcomes. For example, it identified a major hospital was a significant outlier in terms of its positive surgical margin rate (cancer cells left behind after surgery). This led to higher levels of cancer recurrence, additional treatment and costs.

The hospital investigated and identified opportunities for improvement in the supervision of trainees. This work resulted in amendments to training programs.

In addition, the rate of radical surgery (e.g., prostatectomy) for men with low risk disease significantly declined in Victoria after the PCOR-Vic commenced providing benchmark reports to hospitals and clinicians. As a result, there were fewer: patients with a positive surgical margin following radical prostatectomy; men requiring secondary treatment; deaths; and low risk prostate cancer patients receiving unnecessary active treatment.

The 2016 Economic evaluation of clinical quality registries found that for every dollar invested in the PCOR-Vic, a return on investment of $2 was realised. This impact related to assessment of only two of the eleven quality indicators reported by the registry (reduction in positive surgical margin rate and reduced active intervention in low risk patients).

Example 2: Evaluating Telehealth

Enhanced data and information will be crucial to assessing the value and efficacy of MBS services, including those delivered via Telehealth. The Taskforce believes that Telehealth services can be an important means to support patient access but cannot fully replace face to face consultations. This view was supported by the Taskforce's Telehealth Working Group, established to consider the broader issue of Telehealth and help inform the Taskforce's consideration of Telehealth recommendations across clinical committees.

The Taskforce believes that the Government's recent expansion of Telehealth services in response to the COVID-19 pandemic will require careful monitoring to ensure that it delivers high quality patient care and value for money, and does not create unintended consequences. To ensure this, The Taskforce outlined the following principles, stating Telehealth:

- Should be patient-focused, and based on patient need, rather than geographical location
- Must support and facilitate safe and quality services that demonstrate clinical efficacy for patients
- Should be provided in the context of continuity of care between patient and practitioner
- Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care
- Should prefer video over phone, as video offers richer information transfer, with fewer limited exceptions being allowed over time
  - Support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation
  - Should be implemented and modified through time limited transition arrangements
  - Supports different funding models consistent with patients' need, clinical specialty and purpose.
  - Should be guided by contemporary relevant guidelines and principles
  - Require ongoing data collection, research and evaluation into outcomes and utility

The temporary MBS telehealth items support continued safe access to essential primary health services during the pandemic and have helped limit the unnecessary exposure of patients and health professionals to COVID-19. Beyond COVID-19, if telehealth is to be supported it will be important to set strong parameters around the use of telehealth so that it is not used inappropriately. The Taskforce invested significant time and resources into improving after hours GP services, which had been driven by a throughput-focused corporate model and advertised to consumers on the basis of convenience rather than medical need. The Taskforce is concerned there are similar risks around the use of telehealth.

Improvements in data collection will help clinicians, consumers and funders assess whether service delivery via telehealth provides high value care for Australians.

Another important development is the increasing use of patient-reported outcome measures (PROMs). PROMs are questionnaires that help patients to report on outcomes relating to their health. They focus on various aspects of health such as symptoms, daily functioning, and quality of life. The use of PROMs can be valuable in helping to improve healthcare quality and safety.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is undertaking a program of work on PROMs to support further uptake in Australia and internationally through its work with the Organisation for Economic Cooperation and Development and the International Consortium for Health Outcomes Management.

The Taskforce believes further work is needed to build upon and complement these reforms. Throughout the Review, the Taskforce and their clinical committees and reference groups were provided information from MBS data that helped with their consideration. However, the service and payment information from the MBS is not an outcomes measurement tool.

It is the view of the Taskforce that the continuous review of items must occur more frequently and continue to closely reflect evidence-based clinical input. However, it is equally important that this work is underpinned by improvements to meaningful collection and standardisation of health outcome information and patient-reported outcomes. Not only will this enable meaningful decisions by Government on the best utilisation of health resources, it will also help better inform the patient on what their contribution to their health costs will deliver for them as the beneficiary of the service.

Recommendation 8

Introduce standardised health outcome and patient reported outcome measures to enhance patient-level decision making and resource planning and allocation.

Issue: Need for improved data collection and sharing to support evidence-based care and inform service planning

The Taskforce recommends the collection of, reflection on and sharing of data to support evidence-based and data-driven clinical care. This would also support auditing, benchmarking and monitoring of care outcomes, and better data will help identify low value care services. This would also support a continuous review cycle of MBS items, in terms of patient access and quality outcomes.

To achieve this, more information will need to be available about the purpose and content of GP consultations as well as specialist consultations.

The Taskforce recommends that data collection include data to:

- record clinical and patient-important outcomes and process data on topics including mortality, morbidity, functional capacity, re-admissions and PROMs
- facilitate benchmarking with peers and drive quality improvement
- address data integrity, rigour and risk-weighting so as to enable information to be made available to patients and their primary care practitioners to enable informed choices relating to their healthcare
- enable linkages of multiple datasets and interact with state and national level quality improvement initiatives as led by (for e.g.) the Australian Commission on Safety and Quality in Health Care
- include data available from private health insurers, private hospitals, and state public health systems
- align with national key performance indicators, for e.g. that exist for Aboriginal Community Controlled Health Services
- consider of how MBS cost-data, including data on out-of-pocket fees for patients, is shared at both an institutional and individual provider level.

This could also include consideration of establishing national minimum data sets, if required.

This recommendation complements the Taskforce's recommendations on measuring and sharing data, and developing clinical decision support tools to support GP stewardship and increase transparency around decision making while driving market efficiencies through improved competition.

This data could also be used to inform colleges and peak bodies of trends in clinical practice so continuing professional development and other improvement levers can be more targeted. It could

also support clinical audits as a mandatory part of continuing professional development and help enforce greater clinician involvement in mortality and morbidity meetings.

If government can measure the value of healthcare interventions, patients, providers, researchers and funders will have the means to identify and reduce unwarranted variation, errors and wastage. The data can guide service planning at the national and regional level and consequently guide resource allocation by governments, local hospital networks and primary health networks (PHNs).

High performing and innovative practice should be implemented across the system to free up resources to support higher value care. Improvements in patient outcomes over time will also reduce the need for services and lead to greater access for more of the population.

The Taskforce has made significant efforts to correlate MBS funding with the execution of high value activities. It has also identified and recommended the removal of MBS items to reduce the likelihood of low value care occurring and worked to clarify MBS item descriptors for clinicians, consumers, auditors and compliance officers. These efforts aim to support the integration of best practice care for patients, which was a frequent concern raised throughout the Review.

Recommendation 9

Establish appropriate data collection and sharing mechanisms to inform service planning, resource allocation, evidence-based clinical practice, patient consent, and continuous quality improvement.

Issue: Transparency of cost and quality data

There should be an increased focus on supporting value-based healthcare and providing patients with transparency on cost and outcomes when choosing an institution. Increasing the availability and transparency of data on service-level practice will inform choice and improve patient involvement in all aspects of care. It may also improve average standards of quality of care through competition between providers.

As a principle, patients (and ideally their primary care providers) must have adequate information conveyed in accessible language to make an informed decision on a preferred specialist. Currently there is a dearth of data on quality of care in the outpatient setting, and patients do not have access to information on the range of appropriate fees and the value of the service they receive.

There are global trends towards public reporting on quality and performance, with the objective of improving patient information and choice. In the United Kingdom's (UK) National Health Service (NHS), the NHS Choices website has been established for patients to score providers and add commentary about their experience. In addition surgeon-level, risk-adjusted information on mortality rates, waiting times and volumes of procedures is publicly available. GPs in the UK are legally required to offer patients a choice of consultant specialists for referral, along with the above information, under the "Any qualified provider" policy.

To facilitate this improved transparency, the Taskforce recommended as part of its Specialist and Consultant Physician Consulation Clinical Committee (SCPCCC) report that MBS cost data, including data on out-of-pocket fees, is shared at an institutional and individual provider level and consultant specialist risk-weighted outcome data is shared at an institutional and disease specific level. This data should be made publicly available to enable discussion with the GP at the time of referral and the presentation of cost and outcome data should be co-designed with consumers and include a clear explanation of the data and its limitations.

Recommendation 10

Provide transparent publicly available data on the cost and quality of MBS services to allow consumers to more easily make informed choices about their care.

Alternative funding models to support healthcare delivery

Introduction

The MBS, like many national public insurance schemes, operates on a fee-for-service model. This was the subject of much discussion by the Taskforce during the MBS Review. While in many instances a fee-for-service model is an efficient method to support healthcare, the Taskforce also identified instances where it led to fragmentation in service delivery, provided inappropriate incentives, and did not support the best possible care for the patient.

Benefits and limitations of fee-for-service funding

In the context of the MBS, the main benefit of a fee-for-service model is that it is a straightforward transaction that works well for treating patients with short-term ailments. A patient has a need and a specified fee is payable to address this need. When the MBS was conceptualised approximately four decades ago, a fee-for-service schedule represented sensible policy given healthcare often consisted of individual or small group practitioners consulting with patients on a case by case clinical basis. However, some segments of modern medicine have shifted from this model, with many patients now routinely requiring complex integrated care over time and across multiple providers. This is not to say fee-for-service models are past their due date. Many services now, and into the future, are best funded on a fee-for-service basis. It is important, however, to acknowledge that there are circumstances where this model is in conflict with the model of care and that alternative types of funding may be warranted to better underpin the model of care and to support safety, quality and efficiency.

The Taskforce noted while a fee-for-service model can be efficient when dealing with a singular intervention this can become more complex and confusing for patients where multiple interventions or attendances are needed.

There are examples where a single episode of care may involve multiple providers, and multiple items, such as diagnostic or pathology items, and anaesthetists or assistance at surgery. In other instances, chronic conditions often need to be addressed through a multidisciplinary approach, meaning continuous review and management of patient needs over time in order to deliver them the best outcome.

Limitations relating to the fee-for-service model are commonly grouped into four categories (26):

- Rewards volume of services: Subsidising services based on the volume of care provided can reward providers for performing unnecessary services and potentially for undertaking low value care. In these instances, unless the model is subject to cost containment provisions, the funder and patient tend to bear the financial risk rather than the provider (27).
- Does not incentivise coordination: Reimbursing individual procedures and services, rather than the treatment of a patient's condition over an entire care cycle, may incentivise the providers to organise around functional specialties. This can lead to poorly coordinated care, duplication, and limited accountability.
- Perpetuates inefficiency: Rebates do not necessarily reflect the current complexity or the available technology for treating certain conditions. Older, more outdated approaches may attract a higher fee than more modern, safer practices. This is because the scheduled fee for most MBS items reflects historical market prices and forms of treatment with subsequent inflation adjustments. Technological and procedural advancements are common, and these diverge away from the cost inputs that determined the original scheduled fee.
- Rewards intervention over prevention: MBS rebates tend to have a value relative to the time and complexity of the service provided rather than its impact on health outcomes. This can lead to interventions being favoured over watchful wait or prevention due to the impact on provider revenue (28).

Fee-for-service does not reward or encourage spending extra time on prevention or achieving valuable outcomes like minimising preventable hospitalisations, nor does it reward healthcare professionals for efficiently managing people with chronic conditions.

To incentivise these activities, the MBS includes more than 40 items devoted to preventive health and the better management of specific chronic conditions in areas as diverse as screening for cervical cancer, asthma and diabetes management, care planning, case conferences, medication reviews, and preventive health assessments (29). However the evaluation and implementation of alternative funding models will be a key challenge for the foreseeable future in the management of chronic disease, and fees may need to be more flexible and adaptable.

The weaknesses of the fee-for-service service model are evident where market opportunities drive the supply of services. This has led to the negative effects of 'supplier induced demand'[6], or where oversupply creates demand for services that do not correlate with patient need or epidemiological trends (30). In these instances, finite resources, such as specialists, are inequitably allocated across the system and ultimately impact the broader population's access to care.

The Taskforce's consideration of colonoscopy items and subsequent recommendations to more closely align with current clinical guidelines and limit colonoscopies to high-risk patients demonstrates this. The 2018 Australian Atlas of Healthcare Variation noted variation in MBS-subsidised colonoscopies (31). An analysis of service utilisation across Australia identified rates of colonoscopies in some regions that did not appear to match patterns of patient need. Incidence and mortality rates for bowel cancer were highest in areas of socioeconomic disadvantage, while major cities and higher socioeconomic areas had the greatest use of colonoscopies.

These findings were considered by the Taskforce and a series of recommendations were accepted by the Government in 2019 to address these issues. These reforms reduced the risk of performing unnecessary colonoscopies and increased access to services for patients with a greater clinical need.

Another area was the provision of urgent after-hours attendances. This was intended to support patients in need of urgent support where it was not feasible for them to wait until the next in-hours consultation period by a GP. Growth of this program exceeded 150 per cent over the period 2010–11 to 2015–16. Growth in standard GP attendances over the same period was approximately 15 per cent (32). The Taskforce further found that many urgent after-hours visits could have been conducted during the in-hours period (32), with the patient's regular GP.

The Government has already accepted recommendations to better target and clarify the purpose of urgent after-hours services, improve their clinical quality and remove some of the drivers that had promoted inappropriate use of these items. Importantly, these changes also sought to ensure services delivered to people in rural and regional areas would not be adversely affected by these changes. These took effect in March 2018.

6 'Supplier-induced demand' refers to the notion that doctors can influence their patients' demand for medical services to create additional demand for these services. It can arise from actions by doctors linked to self-interest or attempts to promote the well-being of their patients.

Alternative models

The Taskforce considered international examples of different patient care funding systems. For example, New Zealand, Norway, Sweden, England and France have, to varying degrees, moved to a funding model which is reflective of both fee-for-service and non-fee-for-service components.

Case study: Netherlands (33)

In 2015, the Netherlands National Government introduced a new GP funding model comprising three segments.

- Segment 1 (around 75 per cent of spending) funds core primary care services and consists of a capitation fee per registered patient, a consultation fee for GPs, and consultation fees for ambulatory mental healthcare at the GP practice
- Segment 2 (around 15 per cent of spending) consists of funding for multidisciplinary care for diabetes, asthma, and COPD, as well as for cardiovascular risk management – with prices negotiated with insurers
- Segment 3 (around 10 per cent of spending) provides GPs and insurers with the opportunity to negotiate additional contracts –including prices and volumes-for pay-for-performance and innovation

In practice, the majority of healthcare providers are small businesses. As such, the behaviours or choices made by healthcare providers in the delivery of services are influenced by their business model. To be financially sustainable, a provider's business model and resulting care processes and practices need to align with the incentives, implicit or otherwise, of the funding model adopted by a funder.

The Taskforce holds the view that a fee-for-service model supports sustainable business models. However, care delivered under a fee-for-service model is not always sufficient to meet the requirements of patients with complex needs, or where multiple interventions are needed, or where team-based care is required. However, in progressing alternative models, a balance must be achieved between quality, value and outcomes, while maintaining access for patients.

The Taskforce believes alternative funding models should be considered to complement the fee-for-service MBS model to support patients to achieve the best health outcomes possible.

The alternative funding models will need to be underpinned by the effective management of information systems, and accountability mechanisms that measure and deliver value to the patient, and to the funder (i.e. taxpayers). Non-fee-for-service funding models that support improving value for consumers through incentivising high quality, cost-effective outcomes will be of benefit for patients (27) (34). Some key alternative funding models growing in use internationally include case-based or Diagnosis Related Groups (DRG), bundles and capitation (outlined in Box 1), or a mixture of these.

Box 1: Alternative funding models

Case-based payment systems (also commonly referred to as 'Activity-Based Funding', 'case mix', 'healthcare resource groups' or 'payment per case' models) shift from a fee-for-service to a fee-for-case approach. In other words, instead of payment for a single activity or intervention, they look at a patient in terms of the interventions they need to resolve an issue, and the payment reflects the resolution of that issue. DRGs are the most common way to classify different cases, and the funding reflects an agreed price for this case based on the complexity of the intervention needed.

Bundled payment models are slightly different to case-based payments, as they provide funding for an cycle of care for a specific medical condition, or in some cases for a population group. Whereas a case-based payment is treating an issue (such as a surgical procedure) a bundled payment looks after all the needs of the patient for a period of time (which may include the procedure, as well as any preliminary care and follow-up care) to help them receive the care they need. In some instances, a bundled payment may be given to the wider range of health professionals that might be needed to achieve a specified health outcome (for example, a bundled payment could reflect ante-natal, intrapartum and post-natal care).

Capitation-based funding models reflect a prospective, periodic, lump-sum amount to a provider (or group of providers) to take care of a patient. The amount intends to include a range of services as specified by the funder but generally are broadly-based to enable flexibility in how care is delivered, so long as it benefits the patient. Often, the payments are 'weighted' (risk-adjusted) to take account of the fact that some patients require additional support, or more costly services depending on their condition. Sometimes and depending on the services covered they can simply be made on a "per capita" basis.

Each of these alternative models have various advantages and disadvantages. It should also be noted that such approaches do not need to be "instead of" fee-for-service, but can be complementary. This concept is more broadly referred to as a *blended funding* model and may include components of fee-for service, case-based, bundled and/or capitation payments.

It should be noted that while initiatives are being undertaken to support the Taskforce's conception of the future of primary care, including through the consideration of alternative funding models, there are other areas which should be explored. This includes the delivery of some specialist care, including post-intervention follow-up in cancer care, and bundled approaches to the delivery of services in areas including ophthalmology. This will require a significant cultural shift amongst providers, but will improve patient outcomes and ultimately deliver a system well placed to meet the challenges of the future.

Recommendation 11

Evaluate and implement alternative funding models that complement the MBS.

Issue: Rebate relativities in the fee-for-service model

Where the fee-for-service model is appropriate, it is important to ensure that the benefits payable reflect contemporary evidence and health technologies. While the Taskforce only provided advice on fee setting in limited circumstances, this has been challenging to achieve in practice. Adjusting the fees associated with existing MBS items is a contentious issue – it has been contentious throughout this MBS Review, and when explored previously by other groups.

For example, the joint Department of Health and AMA 'Relative Value Study' conducted between 1994 and 2000 (35) (36), was not implemented due to technicalities in assumptions as well as disagreement between stakeholders regarding rebate adjustments (37).

This type of analysis has not been conducted since, nor have alternatives been attempted. One such alternative approach to pricing is the annual negotiation process between the single-payer Canadian Provinces and their respective single provincial medical association that has assisted them in determining equitable and fair pricing (38).

The Review was not tasked with undertaking relative value adjustments but at times did make recommendations when practice or technology substantially altered the time or complexity of a procedure. The Taskforce also examined the issue of financial loadings in the fee-for-service model and the distortions such incentives can create, as outlined below.

Financial loadings in the fee-for-service model

Throughout the course of the Review, a number of clinical committees and reference groups discussed the issue of applying additional financial loadings to the fees (and patient benefits) for particular MBS items. While the rationales for loadings varied, discussions generally reflected three broad categories:

- Incentives: to promote the uptake of items, or service delivery in areas with access issues (such as in rural and remote areas)
- Complexity: to reflect increasing levels of complexity from a 'base' service, usually surgical in nature
- Infrastructure: to recognise additional input costs associated with delivering a service, such as the requirements for specific equipment or technology

PARC noted that adding a loading in a fee-for-service model may lead to an over-rewarding of clinicians that 'specialise' in particular modes of delivery, compared to clinicians that deliver fewer of the same services, but have similar input costs. There is no compelling argument against this principle being maintained in general, noting there are some pragmatic exceptions. At its core, the rebate provides a patient payment and there should be no disincentive between patients based on where they live.

The Taskforce endorsed the following principles and provided them to the clinical committees to guide their recommendations:

- An MBS item describes a unique, discrete service which should be employed consistently across a range of provider and patient settings. MBS fee loadings should not be used for purposes such as: incentivising the uptake of new MBS services promoting service delivery in locations which may have access issues (such rural and remote areas) and compensating for additional capital or other costs associated with delivering a service.

Targeted non-MBS mechanisms are more appropriate and efficient to address such factors.

The Taskforce recognises that fee loadings have created unintended variation and inconsistencies within the MBS and has sought to address this through establishing a principle that financial loadings are not appropriate in the MBS fee-for-service model. This was reflected in the recommendations made by the Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC) and Psychiatry Clinical Committee to introduce a new framework for telehealth services, including phasing out the telehealth loading items for specialist and consultant physician attendances, which had been introduced to encourage uptake of telehealth services in particular geographic areas. The Taskforce supports the creation of a new MBS telehealth framework in its Telehealth Report which

contains a suite of recommendations and principles to underpin and guide the ongoing use of telehealth in the Australian health care setting.

Historical and inconsistent additions to the MBS has led to further variation and inconsistencies of MBS rebates. For example, the SCPCCC examined 143 items relating to attendances by specialists and consultant physicians, and noted that many of these items had not been reviewed since their introduction in the 1970s and are based on rationales that are increasingly dissociated from standard clinical practice. It found that the current structure of attendance items does not accurately reflect the contemporary roles of specialists and consultant physicians and the balance of consultative and procedural work across specialties, does not sufficiently support clinicians to invest in consultative care over procedural work, and does not provide consumers with transparency on the cost or quality of their chosen institution or practitioner. The Taskforce has endorsed the recommendations of the SCPCCC to streamline the majority of consultation fees for specialists and consultant physicians. This would also underpin changes to telehealth items to enable greater consistency of rebates. The Taskforce has sought to resolve the key irregularities in fee relativities and recognises that there is more work to be undertaken in the consideration of time-based consultation items.

Recommendation 12

Investigate a standardised approach and methodology to the setting of fees to ensure these reflect contemporary practice and available evidence.

GP stewardship

Introduction

GPs play a pivotal role in supporting an effective and efficient healthcare system through responsible stewardship of healthcare resources. The central nature of the GP's role is reflected in the volume of services directly initiated by GPs, which represent more than half of all MBS and PBS activity and expenditure (10)(39).

GPs are also stewards of the health journeys of individuals, providing high-quality primary care that can positively impact a patient's health outcome, for example, by effectively managing chronic conditions resulting in fewer emergency department visits and hospitalisations.

The Taskforce recognises that a strong relationship between the patient and their GP is at the heart of the Australian health system, and must continue to be supported.

Issue: GP stewardship of the patient health journey

Partnering with consumers is central to the stewardship model, reflecting both the role that consumers play in health resource utilisation and the extent to which their actions enhance (and at times diminish) appropriate stewardship of healthcare resources.

A therapeutic GP-patient relationship can foster this partnership. Ideally, the GP elicits and discusses the consumer's ideas and beliefs about their health, as well as their fears and concerns about current problems and their expectations regarding their healthcare. The GP then outlines the relative risks of differential diagnoses and management options, seeking to partner with the consumer in his or her decision-making. The overall aim is to address the consumer's presenting concerns and existing health problems, while also reducing the risk of future problems through evidence-based health promotion and disease prevention strategies.

Evidence indicates that having a regular GP is beneficial for patient outcomes, patient experience and value for the system. Stronger connection between the patient and the GP-led practice team can assist patients to navigate the health system, and can ensure more seamless communication between primary and hospital care.

The Taskforce made recommendations to Government to improve the recognition of the relationship between patients and GPs by supporting longitudinal care delivered through a partnership model of care underpinned by patient enrolment with a GP. The work of the Taskforce was reflected in the announcement in the 2019–20 Federal Budget of a new, Voluntary Patient Enrolment initiative.

Patient enrolment will support a fundamental shift in how services are remunerated and how patients receive care.

Voluntary patient enrolment

Using voluntary patient enrolment to enable block or a mix of blended funding, as opposed to solely relying on a fee-for-service model, will allow GPs to more effectively manage health resources with regard to individual patient needs, preferences and circumstances.

This will be particularly effective for people with chronic and complex care needs whereby Chronic Disease Management and Health Assessment items would be restricted to those practices where a patient is enrolled, strengthening continuity of care.

Expansion of voluntary patient enrolment to the whole population will encourage practices to build continuity of care into their business models, ensuring support for longitudinal care and population health as well as acute, episodic care.

The Taskforce acknowledges this policy is still being developed with stakeholders, and its introduction is likely to be impacted and modified by the Government's response to the COVID-19 pandemic.

Recommendation 13

Appropriately fund and support the Voluntary Patient Enrolment initiative to the whole of the Australian population to improve continuity of care.

Issue: GP stewardship of healthcare resources

The Review and the ACSQHC have highlighted the considerable geographic variation in the use of health services. It is clear that there are opportunities to improve the consistency of access to high-value, best practice health services, and to reduce low value care and waste in health resources. The significant variations between the rates of GP utilisation of health services extend across diagnostic imaging referrals, pathology requests, prescriptions and referrals to specialists. Examples of variation include:

- In 2014–15, about 20 per cent of requesting doctors accounted for two-thirds of (TSH) thyroid tests and analysis showed there is a long tail of GPs who request far more TSH tests than their peers. For example, a group of 310 GPs requested 40–173 TSH tests per 100 patients compared with the median of 7.3 tests (43).
- In 2015–16, in diagnostic imaging, 10 per cent of GPs request more than 160 lumbosacral spine x-rays per 10,000 patients than the median of their peers, only 50 per 10,000 (42)
- In referrals to specialist services, there is 36 per cent variation in colonoscopy rates between Queensland and Western Australia (31)(44).

Increased testing may cause direct, as well as indirect, harm through further consequential testing, medication or unwarranted procedures. While some variation is desirable and may reflect differences in community needs, many patients are receiving unnecessary or inappropriate tests, medications and referrals. Good GP stewardship implies requesting the right tests and making appropriate referrals to maintain quality care that protects patients from harm.

Clinical Decision Support

Clinical Decision Support (CDS) can be defined as 'the provision of advice at the point of care (when decisions are being made by the medical professional) that is tailored to the clinical context of the specific patient.' CDS can enhance high value advanced imaging requests, reduce inappropriate overuse and misuse, and provide a source of clinical knowledge for requesting clinicians.

The Taskforce recommends a focused effort to support the use of CDS tools that are currently available and to facilitate the development and expansion of CDS tools to enable appropriate use of health services.

The Taskforce recommends developing CDS which can integrate all MBS item descriptors, and subsequently consider mandatory CDS for selected diagnostic imaging items, and possibly for selected pathology and other areas. This would be an initial step to facilitate the appropriate clinical use of these services.

CDS is primarily a tool to focus on better pathways for clinical care by GPs. While pathology and diagnostic imaging providers are central, primary care must be the driver and enabler of tools that support patients.

CDS would help to address some of the variation in GP referral rates and support clinicians to request the right test at the right time, leading to improved patient care and enhance the quality and safety of practice.

Example: Lower back and head imaging

Introducing mandatory CDS for requesters of lower back and head imaging would require them to consult clinician-developed, government-approved, evidence-based appropriate use criteria through a CDS system prior to requesting imaging (X-ray, CT or Magnetic Resonance Imaging (MRI)) for the lower back or head. This can be expected to ensure that patients receive imaging based on consistent and evidence-based practice, reduce exposure to radiation from unnecessary X-rays and CT scans, and have a positive impact on patient anxiety resulting from over-diagnosis. A reduction in unnecessary testing will also result in reduced out-of-pocket expenses and decreased wait times for services.

Recommendation 14

Support and expand the use of clinical decision support tools at the point of care to integrate MBS item descriptors and enable appropriate use of health services.

Issue: Quality use of data to better support GP stewardship

The meaningful collection of quality data and activity metrics has enormous potential to support GP stewardship, providing GPs with a better understanding of their practice and encouraging improvement in their professional practice.

These metrics should focus on existing, readily available MBS and PBS data for a select number of high-value, high-variation practice areas. Data on selected metrics could be provided in regular intervals to PHNs and to practices and individual GPs for self-reflection.

Quality metrics should build upon those being designed by clinician-led projects within the ACSQHC and the Practice Incentive Program. Quality metrics could include:

- percentage of people who have received all vaccinations per the National Immunisation Program Schedule
- percentage of people with diabetes who have received an annual cycle of care
- proportion of people at risk of cardiovascular disease who have had their absolute risk assessed

Research is needed to define an appropriate set of activity metrics and to risk-adjust data to support comparability between practitioners. Activity metrics could include:

- Pathology: requesting activity levels for iron studies, B12 markers, thyroid function tests, and urine examination
- Diagnostic imaging: using MBS data to measure requesting activity levels for head CT and MRI, lumbosacral spine CT and X-ray, and knee MRI
- Prescriptions: Using PBS data to measure prescribing activity levels for antidepressants, antipsychotics and sedatives in the elderly, and for antimicrobials

Data and metrics should be matured to provide a deeper level of insight into GP provision of care. To do so, a number of key questions need to be addressed through research:

- How can we capture referrer data in order to provide data on referral rates?
- How can we link activity data to diagnoses (and therefore clinical best practice/guidelines) to provide transparency on the level of appropriateness of care?
- How can we risk-adjust activity levels to normalise against the risk/need in particular patient population? How can we convert this into a meaningful estimate of expected total cost of care for a GP's patients?
- How can we capture data on PREMs and PROMs, to supplement activity and quality metrics?

- How can we provide greater transparency on the patient journey (integrated across components of the health system)? Eg, by incorporating measures of potentially preventable hospital admissions?

The appropriate use of data would underpin the role of GP stewardship in the community, and promote consistency in how Australians can expect to receive data-informed care in the future.

Example: Swedish strategic programme against antibiotic resistance (45)

Levels of antibiotic use and resistance in Sweden are now among the lowest in European Union countries. Between 1992 and 2016, the number of prescriptions per 1,000 inhabitants per year in outpatient care, including primary health care, decreased by 43 per cent, while among children aged 0–4 years they decreased by 73 per cent. Adherence to treatment recommendations has been increasing gradually and, notably, sales of antibiotics used for respiratory tract infections have decreased. There has been a major shift from broad- to narrow-spectrum antibiotics in primary and hospital care, in line with recommendations. Important factors for change include setting a national target for the number of prescriptions in outpatient care and defining quality indicators based on treatment recommendations, as well as providing local feedback to prescribers.

Recommendation 15

Develop and support GP stewardship, including training, financing and research on a set of quality data metrics, to improve patient outcomes and health system efficiencies.

Harnessing innovation to deliver contemporary care

Introduction

A recurring message throughout the Review was that more effort and investment is needed to recognise and support evidence-based innovation and address system barriers across the Australian healthcare system.

In 1950, it took 50 years to double medical knowledge. By 1980 our knowledge doubled every seven years. In 2020, it is estimated to be just 73 days. Innovations in genomics, stem cells, robotics, artificial intelligence, e-health, remote sensors, telehealth, 3D printing and data and analytics continue to change medicine and research, and advance knowledge and application. With this ever increasing rate of change, it is imperative that services are assessed, delivered and structured to keep pace with this rapid evolution and ensure a contemporary system is in place for the future.

The Taskforce concluded that the latest changes in practice, clinical evidence, and innovative treatments need ongoing assessment, and systems need to be responsive to technological advancement and changes in practice for Australia to keep pace with the world.

Defining innovation

Innovation is more than new technology. It is also the process of generating and implementing new ideas, new treatments and procedures and new ways of working and delivering safe, high quality, high value care. Often this includes the structure and governance required to develop an idea, the redesign of an existing idea, or the extension of an idea either to market, or into professional standards and practice. Innovation in the health context can include:

- new health technologies[7] such as the use of artificial intelligence to support and guide clinical decision-making, the use of remote sensors and robotics, 3D printing which may allow more tailored and more accessible care
- new broader technologies, which, while not unique to health, can fundamentally change how we interact, communicate and deliver care for patients outside the traditional bricks and mortar of a practice or institution. A significant example of this is the evolution of telehealth and e-health, particularly during the COVID-19 pandemic
- information and data capture, which allow the ability to better understand the evidence, needs, clinical impact and outcomes for patients at the local practice level and to enable effective service planning and delivery which meets the often complex and diverse needs of patients.

The Taskforce has made many recommendations that support new and innovative approaches to delivering care. These include the guiding principles for telehealth use and a new model of care for patients requiring renal dialysis in remote areas. Though reforms such as remote renal dialysis do not relate to new technology or services, they highlight that existing services can be redesigned and improved, while also expanding access.

The Taskforce acknowledges there is much “work in progress” relating to innovation in Australia. While the COVID-19 pandemic has prompted the rapid introduction and adoption of telehealth to address an immediate safety issue, there has been growing evidence of the benefit of synchronous (for example, videoconferencing) and asynchronous (for example, use of email) use of technology to improve patient care. Areas such as electronic health records, interoperability of clinical systems and improvements in how data can be collected and inform patient care, and the use of decision-support tools demonstrate the significant progress in the last decade alone.

7 Health technology is broadly defined as drugs, diagnostic tests, including indicators and reagents, devices, equipment and supplies, medical and surgical procedures, support systems, and organisational and managerial systems used across the spectrum of health care (78).

Issue: Lack of defined pathways to leverage innovation

Australia's MSAC processes for assessing innovative health technologies are highly regarded internationally. However, the organisation and operation of these assessments across the health system is fragmented and can result in cost and time implications for sponsors, consumers and Government. This can potentially delay consumers access the latest health care.

While there are many innovators in Australian healthcare, there is no clear pathway to inform or support the rest of the profession in the use of evidence-based innovation and often very valuable innovations are undertaken by individuals in their own hospital or practice with no ability or process to spread these across the health system. The current MSAC is appropriate for significant innovations where there is commercial sponsorship of the MSAC application, but is a barrier to many other evidence based innovations because of the perceived costs and length of its processes.

A particular problem is that many innovations are incremental changes to existing process or developed through new technology and services. These innovations have significant benefits for consumers. Recognising a fit-for-purpose approach to innovation will support the realisation of small, timely, incremental changes as well as the implementation of latest technologies.

Process improvement type innovation has significant implications for both improving quality for consumers and decreasing cost to the health system. There are numerous examples from overseas and domestically of, for example, the value of coordinated care with one stop shops for consumers to be assessed, diagnosed and given a treatment plan. Often consumers who might be referred in the first instance to a surgeon for treatment will be just as well managed conservatively if they have access to the appropriate diagnostics and clinicians in one setting. This provides cost effective, value based care coordinated around the consumer, rather than single providers. There needs to be a way to assess these systems of coordinated care and see how they would work best in the Australian health system.

Options for Change

A specific, high level federal body to support national evidence-based innovation leadership, would drive the evaluation and implementation of innovations in the Australian healthcare system. This body would act on behalf of all stakeholders: government, health service providers, researchers, and consumers. It could better leverage translational research efforts, particularly in the service delivery arena. This would also provide a formal way to fund, conduct and publish research on how Australian healthcare can best benefit patients and the community.

The development of this new body should learn from bodies overseas such as the Agency for Healthcare Research and Quality (AHRQ) in the United States, the big data information collected in the Israeli health system by the Clalit Research Institute, the World Health Organisation's (WHO) Collaborating Center on Non-Communicable Diseases Research, Prevention and Control, and the UK's National Institute for Health Research (NIHR).

The NIHR undertakes systematic reviews and primary research on a wide range of public, preventative and clinical health questions about innovations to improve care, care pathways, and value to consumers. The NIHR includes a HTA program for important innovations lacking a commercial sponsor. It also funds the *NIHR School for Primary Care Research,* consisting of nine leading academic centres for primary care research in England. It aims to increase the evidence base for primary care practice through high quality research, strategic leadership and training.

A similar body in Australia would require cooperation and assistance from the Medical Research Future Fund's (MRFF) *Primary Health Care Research* initiative, the National Health and Medical Research Council (NHMRC), universities, and professional and peak bodies to ensure its success

at identifying gaps in necessary research. It would also enable consideration of areas where more targeted evidence is needed, to identify the best level and model of investment to meet patient need and clinical outcomes. This new body should include public health and preventative care as these are areas where significant value can be delivered to consumers, cost effectively.

Significant work will be required to develop this new mechanism, particularly in balancing how risk is shared by innovators, providers, consumers, and government while evidence is developed and assessed.

Taskforce considerations

It was noted that several priority driven research questions are often neglected as they are not of interest to commercial sponsors nor current research funders:

1. Clinical questions, such as the value of echocardiogram for monitoring heart failure
2. Behavioural questions, such as whether displaying costs on tests would change clinician or patient behaviour
3. Health systems questions, such as appropriate uses of telehealth
4. Funding questions, such as the benefit of an alternative payment models.

The work would require several complementary elements to include at least:

1. Monitoring current and newly approved MBS items for signals of inappropriate variation in practice, significant overuse or underuse, and establishing a minimum data set where appropriate
2. Horizon scanning for innovations that have potential to improve value to consumers, but which are unlikely to have a commercial sponsor
3. Commissioning evidence synthesis for promising innovations, to ensure evidence-based innovations are supported in a timely manner
4. For promising innovations with insufficient evidence, consideration of new primary research to evaluate their impact.

The Taskforce recommends the creation of an Australian NIHR to undertake system and policy-based research, which would be initiated or commissioned by health providers, Commonwealth and State Governments and policy developers. Its scope would contrast with that of the NHMRC, which currently focuses on investigator-initiated research, with a small number of targeted calls for specific public research.

Primary care research including preventive health research is poorly valued, yet it is critical to reshaping our health system for the future needs a sustainable structure and sustainable funding.

The Australian NIHR could sit within the NHMRC and be supported by the MRFF, with matching funding provided by other stakeholders, including the States.

Recommendation 16

Create a single body (an Australian National Institute for Health Research) to provide current health services research to support evidence-based innovation.

Recommendation 17

Develop a national framework to leverage the benefits of prevention and primary healthcare, by building on primary healthcare research in its early stages.

Issue: Support for controlled trials of policy initiatives

This report earlier detailed the need for an enhanced data infrastructure to focus a real-time and retrospective lens on healthcare quality and value. Australia is well positioned to broaden the use of an underutilised methodological approach – controlled trials of *policy* initiatives (as opposed to clinical). Clinical trials are most commonly associated with drugs, procedures and devices, but there are notable examples of trials that involve health policy initiatives. These trials test innovations in the delivery of services, whereas others can focus on financial incentives for providers of care.

Partnerships between government departments and agencies, including an Australian NIHR equivalent, clinical colleges, associations, consumer representatives and academic researchers could design and test bespoke policy initiatives through prospective controlled trials allowing for evidence generation of the most appropriate and effective reform options.

Recommendation 18

Create a national infrastructure to support and prioritise controlled trials of novel health policy initiatives, as currently occurs for trials of clinical innovations.

Consistency across surgical procedures

The Taskforce established 27 committees which reviewed items from Category 3: Therapeutic Procedures, Group T8: Surgical Operations (T8), which considered more than half of all items on the MBS.

The Taskforce noted that many of the clinical committees examining the T8 items encountered similar issues. The Taskforce examined these cross-cutting issues and its objectives were twofold: update individual items in line with the Taskforce approach, and consider whether there may be opportunities to apply some of these observations or 'lessons learned' more broadly to enhance the operation of the MBS and improve consistency across its items. The Principles and Rules Committee (PARC) played a critical role in this process.

Where contradictory recommendations from committees arose, the Taskforce assessed and recommended the most appropriate course of action to the Government. Measures to address consistency were designed to build a more coherent MBS that rebates patients consistently and fairly across each medical speciality.

This section of the Report sets out some of those observations, which the Taskforce believes should be considered as part of any future review of the MBS, including the Continuous Review outlined in Part Three.

Issue: The Complete Medical Service Principle

In addition to the review of MBS items, the Taskforce sought to consider the broader principles of the MBS early in their work, including consideration of the "complete medical service" principle.

The Complete Medical Service Principle

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

This principle was considered extensively by PARC, in conjunction with the principle of the multiple operation rule. PARC noted that there is obvious tension between the two notions – firstly, that all MBS items are a complete medical service, and secondly, that multiple MBS items are billed for a single episode of care. In practice, it is commonplace for many surgical procedures to be billed using different combinations of multiple item numbers for the same surgery, noting that this is partly a symptom of the out-of-date nature of many items and their descriptors prior to the Review. The consequences of this practice include:

- Patients receiving the same service receiving different levels of Medicare benefit
- Patients having increased out-of-pocket costs if providers choose to charge an out-of-pocket cost for each item listed on the patient invoice
- Increased MBS expenditure from higher numbers of items claimed, without proportionate increases in the care provided to patients

During the Review, consideration was given to the possibility of restricting the benefits paid to a maximum of three MBS items in relation to a single procedure, and a maximum of six items for bilateral procedures. The existing multiple operation rule would still be applied to these items. Consideration of a maximum number of items arose from MBS data showing that 94 per cent of MBS benefits paid are for episodes where three or fewer items are claimed. In addition, when more than three items are claimed in a single procedure or episode of care, there is often greater inter-provider variability in benefits claimed for the same services. This can lead to less transparency

and greater out-of-pocket costs for patients and increased MBS expenditure in situations that do not necessarily improve patient care.

Surgical committees were asked to analyse co-claiming data to identify trends where the same group of three or more items are consistently co-claimed and consider whether these represent a complete medical service. It led to many situations where recommendations were made to consolidate items in the interests of improved transparency and patient care.

Committees approached their adherence to the complete medical service principle by either:

- Complete restructuring of items
- Consolidating items
- Introduction of new items to reflect more complex procedures
- Inclusion of co-claiming restrictions where a procedure is implicit to another.

The Taskforce acknowledges that there may be situations where, for genuine clinical reasons, it may be appropriate to provide rebates for more than three items in a single episode of care. Examples of this are found in urology, where many cystectomy procedures require more than three items. However, in the context of any future Review of items, or consideration of new surgical procedures on the MBS, the Taskforce recommends this principle be adopted and applied as part of a standardised approach in the interests of the patient.

Principle

There is benefit in adopting a standardised and structured approach to the application of the complete medical service principle in T8 items to reduce unwarranted variation.

Issue: Improved standardisation and transparency of schedule fees

The work of the Taskforce and clinical committees related primarily to providing clinical advice on services. However, they also examined concerns about whether the current rebate adequately reflected the service being performed, taking into account a range of factors including advances in technology, and the time, skill and complexity required for performing new procedures. Committees made recommendations to correct significantly inappropriate rebates, either by recommending reductions in rebates or by recommending increases.

However, these recommendations varied in approach. Some committees recommended specific dollar amounts for current or new rebates, while other committees recommended a proportionate change to rebates, or adjusting a rebate in line with comparator items. Where items were recommended for consolidation, some committees recommended an average or a weighted average of the combined rebates, while others recommended the rebate for the combined item reflect the sum of the combined services.

The Taskforce recognises that there would be significant benefit in establishing a standardised and transparent approach to setting rebates. One option would be to use time as a multiplier, in line with the Taskforce's recommendation to introduce time-tiered attendance items for specialist and consultant physician attendances. A similar approach could be investigated for procedural items.

Principle

There is benefit in establishing a standardised and transparent approach to setting schedule fees to guide any future proposed changes. Changes to the schedule fees associated with procedural items should use an equitable methodology to facilitate this process.

Issue: Addressing surgical procedures where different approaches are appropriate and available

For many surgical procedures, there are alternative ways by which the surgeon can access the operative field ("the surgical approach"). For example, access can be gained by means of an open procedure or by laparoscope.

A significant number of clinical committees discussed the surgical approaches used to perform particular procedures and made recommendations aimed at making items 'agnostic' to the surgical approach used.

Clinical committees noted that such 'agnostic' recommendations:

- reflect current surgical best practice
- support the surgeon to choose the appropriate procedure for the patient based on the surgeon's expertise and experience, benefits and risks to the patient, patient choice, and the patient's pathology
- help simplify the MBS, by allowing multiple surgical approaches within one item and reducing the need for duplicate items separated by approach, and
- better serve to future-proof the MBS for emerging technologies.

For example, the Urology Clinical Committee recommended changes to item 37200 for prostatectomy to specify that the item covers laparoscopic or robot-assisted surgical approaches, in addition to an open approach.

Although these procedures traditionally used an open surgical approach, technological development in this area of practice has introduced alternative possible approaches, which should be included in this item. Recently, laparoscopic and robotic-assisted approaches have been developed and have become increasingly popular ways of performing prostatectomies, and research demonstrates that these approaches produce equivalent outcomes (24). The Government has agreed to amending 37200 and changes are scheduled for later this year.

The Taskforce considered that while selection of surgical approach is considered one of clinical judgment, how the MBS describes and remunerates procedures by varying means of approach requires consistency.

The Taskforce agreed that, wherever reasonable, rebates for T8 items should not depend on the approach used unless a particular method results in a clear benefit or reduction of risk. Consideration was given as to whether all possible surgical approaches should be listed in the item descriptor. It was determined that the preferred words of 'by any approach' better allowed for future changes and emerging technologies. Sharing of data on the outcomes of various surgical approaches would assist consumers in joint decision making with their clinician. This also simplifies the MBS by reducing the need for duplicate items separated by approach.

This principle would also be appropriate to extend to diagnostic imaging, where tests that can have very similar patient outcomes can be remunerated at significantly different fees.

Principle

Wherever reasonably appropriate, there is benefit in setting a single rebate for an MBS procedure item where different surgical approaches can be used. This would allow appropriate choice dependent on risks, benefits and patient needs.

Issue: Information sharing, including photographic or histological evidence within some procedures

Many clinical committees recognised the importance of recording and sharing information in order to improve patient safety and encourage best clinical practice.

Some committees recommended mandating photographic or histological documentation of particular surgical procedures to demonstrate the clinical need for a procedure to be performed, and thereby reduce non-essential procedures being performed. Other committees made recommendations to enhance the functionality and encourage adoption of electronic health records such as My Health Record.

For example, the Cardiac Services Clinical Committee identified a strong need for a platform to share diagnostic images and reports. This would help reduce unnecessary tests and/or repeat services because images would be available to any provider who required them to guide clinical decision-making. This would also reduce waiting times for vital treatment, reduce patient inconvenience and overcome geographical barriers.

The Taskforce supports the sharing of information and documentation between clinicians to support patient safety and best clinical practice. Further work is needed on systems to review evidence and manage compliance. Determining the cost implications of such system changes would also be an important element for decision-makers.

Principle

There is benefit in investigating options to encourage and support the sharing of information and documentation to support high quality care, including the use of photographs or histology where clinically appropriate.

Issue: Synchronous surgeries and the MBS

Synchronous or conjoint surgeries are where two or more surgeons or surgical teams operate simultaneously on the same patient. For some surgical procedures, conjoint surgeries constitute best practice by reducing the duration of the operation.

Committees noted that there are already existing items for conjoint surgery in some parts of T8 but not others and that some parts of T8 do not adequately reflect the benefits of conjoint surgeries.

For some very complex procedures (e.g. pelvic exenterations), up to seven surgical teams may be involved and some committees felt the MBS does not accommodate for complexity of procedure.

Committees noted that where the MBS is insufficient in recognising conjoint surgeries, each surgical team may exercise discretion in selecting what items to bill, which can result in variation in billing practices and lack of transparency for consumers.

Future consideration may be given to establishing MBS mechanisms by which to incentivise conjoint surgeries for procedures, in cases where the involvement of more than one surgical team has been shown to improve patient outcomes and reduce rates of surgical complications (e.g. through shorter time under anaesthesia).

Equitable and transparent remuneration of surgeons involved in two-team surgeries, based on responsibility for aftercare, is an important consideration.

Principle

There would be benefit in modifying the MBS, where appropriate, to allow equitable and transparent reimbursement of more than one surgical team operating on a patient simultaneously to improve outcomes and postoperative complications.

Issue: Including imaging guidance in the item descriptor

Several committees reviewed items that are either commonly or exclusively performed under image guidance. In some cases, committees considered that 'best practice' has evolved to depend on the use of image guidance to ensure the greatest safety and efficacy of the procedure.

Several committees made recommendations around imaging-guided procedures and considered whether image guidance should be mandated or included in the item descriptor, and whether particular imaging modalities should be specified.

The Taskforce believes that mandating best practice in relation to this issue and using the item descriptor to confirm this is a good way forward for enhancing quality of care for consumers.

Principle

There may be benefit in requiring image guidance where it is considered best practice care, to enhance patient safety.

Issue: Amend bilateral procedures

In reviewing items for surgeries that may be performed bilaterally, committees made recommendations to separate items into right and left sides or amend descriptors to require the same item to be used for bilateral procedures.

For example, the Orthopaedics Clinical Committee recommended that item 49517 (knee hemiarthroplasty) be split into two items: one for unilateral unicompartmental arthroplasty and one for bilateral unicompartmental arthroplasty. The Committee noted that the MBS did not include an item for simultaneous bilateral unicompartmental arthroplasty procedures, and that the lack of a bilateral item might incentivise some providers to perform two separate operations over different days. Their recommendation for a new bilateral item seeks to reduce this incentive.

The Plastics and Reconstructive Surgery Clinical Committee also made a significant number of recommendations relating to bilateral procedures in particular, for bilateral breast surgeries. This reflects the fact that more patients are now having both breasts treated at the same time, and to simplify billing for patients and providers.

Several other clinical committees, including the Otolaryngology, Urology, Gynaecology clinical committees, made recommendations to introduce a range of bilateral items to improve patient outcomes and the delivery of MBS services.

Principle

There is benefit in developing appropriate bilateral equivalents of unilateral items where there are anatomically paired structures which are operated on concurrently.

Issue: Time tiering for surgical procedures

It is difficult to compare complexity, particularly across surgical disciplines. The Taskforce identified time-tiering as a way of addressing this and recommended that the Department investigate the practicalities of such a system.

Time-tiering refers to the average time for a procedure across Australia (using the first claimed MBS item) and not the actual time of a procedure as this would more reflect the experience and competence of the proceduralist rather than complexity. If such a system was implemented, it would be possible to determine an equitable fee per unit of time.

Although time tiered surgical items were considered by several committees, only a limited number made recommendations to create time based procedural items. The Taskforce recognises the complexity of moving this part of the Schedule to be time based. However, the Government should give serious consideration to implementing this as it would significantly simplify the MBS, and provide equity of work done across all the different surgical specialities.
Time may not always be a reasonable surrogate measure for the complexity of a procedure. Time based items however offer the benefits to providers of more just and balanced remuneration, using an objective measure that considers all surgical specialties more equitably. The time considered should be based on the average time for a procedure using Australia wide data collected. Where time alone may be deemed an insufficient surrogate measure for complexity, future consideration may be given to a model that recognises time as one of several factors used to determine appropriate remuneration for the item.

Principle

There is benefit in investigating the practicality of a time-based system of remuneration for each surgical sub-speciality, to facilitate more equitable payments for the most performed procedures in each T8 subgroup.

Issue: Increased use of multidisciplinary teams (MDTs)

Multidisciplinary team case discussion has been acknowledged by clinical committees as the standard of care for many clinical conditions and chronic illnesses, and consideration should be given as to how to incentivise MDT involvement through the MBS.

A number of clinical committees made recommendations to add new items or refine explanatory notes in order to recognise and encourage best practice in multidisciplinary care for particular conditions.

The Specialist and Consultant Physician Consultation Clinical Committee examined the use of consultation items for multidisciplinary case conferences, and made recommendations to increase the uptake and quality of multidisciplinary case conferences by introducing a simplified framework of case conference items and expanding access to all specialists and consultant physicians, as well as allied health professionals and nurse practitioners. The recommendations also encourage GP participation and shared decision-making with patients, which have also been reflected in primary care reports endorsed by the Taskforce.

Until such time that access to MDT meetings is universal across Australia, including rural and remote Australia, the Taskforce acknowledges it is premature to mandate MDT. However, given the demonstrated benefit a multi-disciplinary approach can offer to improve patient care, it is recommended such practices are encouraged, and consideration be given to the evolving technology infrastructure that could promote this practice across Australia (such as telehealth).

Principle

There is benefit in incorporating multidisciplinary team care into explanatory notes where multidisciplinary case discussion has been shown to improve patient outcomes.

Recommendation 19

The Taskforce recommends the principles and 'lessons learned' outlined in this chapter should be considered as part of a continuous review framework. This includes:

- adopting a standardised and structured approach to the application of the complete medical service principle in T8 items to reduce unwarranted variation,
- establishing a standardised and transparent approach to setting schedule fees to guide any future changes and using an equitable methodology for changes to schedule fees associated with procedural items,
- wherever reasonably appropriate, setting a single rebate for an MBS procedure item where different surgical approaches can be used, to allow appropriate choice dependent on risks, benefits and patient needs,
- investigating options to encourage and support the sharing of information and documentation to support high quality care, including the use of photographs or histology where clinically appropriate,
- modifying the MBS, where appropriate, to allow equitable and transparent reimbursement of more than one surgical team operating on a patient simultaneously to improve outcomes and reduce postoperative complications,
- requiring image guidance where it is considered best practice care, to enhance patient safety,
- developing appropriate bilateral equivalents of unilateral items where there are anatomically paired structures which are operated on concurrently,
- investigating the practicality of a time-based system of remuneration for each surgical sub-speciality to facilitate more equitable payments for the most performed procedures in each T8 subgroup, and
- incorporating multidisciplinary team care into explanatory notes where multidisciplinary case discussion has been shown to improve patient outcomes.

Considering these principles will improve consistency across MBS surgical procedures and assist in creating a more modern, transparent system for consumers.

Part Three: A continuous review mechanism for the MBS

The Taskforce has laid strong foundations for a future continuous review mechanism. This mechanism would help ensure the MBS is contemporary, safe, sustainable and responsive to changes in evidence, best practice and changing population healthcare requirements.

The MBS is at the core of Australia's healthcare system, yet there is no capacity beyond the Taskforce's work to deliver ongoing assurance of the relevance, appropriateness or effectiveness of *existing* items on the schedule. The Medical Services Advisory Committee (MSAC) plays a role here, for example by comparing the safety, efficacy and cost-effectiveness of *new* items to existing practices when conducting HTAs. However, as the MSAC is perpetually overwhelmed with the volume of new and emerging services and technologies in modern healthcare, it lacks capacity to commit a comparable focus on thousands of existing legacy items and services. Further, its focus on HTA necessarily limits its ability to evaluate consultation services in primary care and mental health which are now so much of the focus of patients, and government expenditure.

Five years of extensive, broad-based consultation with the health sector and consumers has resulted in widespread support for the Review process. Many stakeholders have expressed strongly there is a need for ongoing review to deliver benefits for patients and providers beyond the end of the Taskforce's work. In addition, there are significant numbers of Taskforce recommendations to Government that require continuous monitoring, research and assessment to maximise system benefits and reduce any unforeseen consequences that may arise during implementation.

During the course of the Review, the Minister referred several matters for consideration by the Taskforce, where there might not have been sufficient evidence base to enable assessment by the MSAC, but where a gap in Medicare funding existed. There will undoubtedly be continued need for broad based and independent advice on clinical practice matters. Such a framework would be of significant value to government and the community.

Further, the cost of the MBS is predicted to exceed $30 billion per annum from 2022–23 (1). Currently, there is no review process for the items that underpin this expenditure. The Government does not have an effective mechanism to measure or advance the effectiveness, appropriateness or overall value of this expenditure without expanding the capacity for ongoing review.

The need to establish a continuous oversight mechanism for the MBS

Creating a continuous program to review existing items will be a substantial step forward in providing a safer, contemporary health system that is accountable, transparent, cost-effective, and sustainable.

Without the ability to review and integrate change, patients may be at risk of undergoing unsafe or outdated medical procedures, or missing out on contemporary, more effective approaches to care. A continuous review provides a novel and comprehensive approach to facilitate the ongoing assessment of safe, effective, high value care and enable review of high cost items.

The PBS has a defined and established review mechanism through its Drug Utilisation Sub Committee (DUSC). The Government oversees post-market monitoring and assessment of listed medicines to ensure safe, high value, effective care for patients. Comprehensive methods are employed to measure, for example, that actual diffusion of medicines matches what was expected based on projected population needs. Coupled with the work of the Pharmaceutical Benefits

Advisory Committee, this is a robust and effective means of responding to advancements in new medicines, treatments and health technologies. A continuous review of the MBS would achieve similar goals.

As an example, the Orthopaedic Clinical Committee (OCC) showed how medical best practice can rapidly change, and recommendations can require updating within fewer than 12 months. Processes for and assessment of reimbursement need to match the flexibility and innovation delivered by front line health services.

Why a continuous review: Orthopaedic MBS items and the speed of change

The review of 599 orthopaedic MBS items was undertaken between 2016 and 2018 by the OCC, supported by six specialised working groups.

The OCC made 170 recommendations, including amendments to approximately 300 item descriptors, deletion, or consolidation of 140 items and creation of 200 new items.

The OCC's report was endorsed for Government consideration in December 2018.

In 2019, the requested that due to the advancement in orthopaedic procedures and technology, and the need to reflect best medical practice in the recommendations, the report be updated.

The Taskforce agreed it was important to ensure the latest evidence was considered before it made its recommendations to the Government. Therefore, this work was undertaken, and the report and its recommendations revised accordingly. For example, item 49221 required updating to reflect that aspects of the procedure could (by that time) be performed arthroscopically.

The Taskforce met in August 2019 to consider the updated OCC Report.

In January 2020, the Minister for Health endorsed the MBS Reviews Taskforce Report on Orthopaedics for implementation.

A continuous review would commit to the critical task of monitoring clinical evidence and its impact on high-value care. It could work in concert with system integrity to assess if changes to items would improve clarity for providers and patients as well as providing opportunities to identify further efficiencies for the schedule and opportunities to invest in high value care. This links to the importance of data, and the role it plays in supporting high value care, as detailed in Part Two of this report.

Throughout the Review some item changes resulted in the need for rapid clinician behaviour change, such as prohibition of the co-claiming of consultation item numbers with procedure item numbers. For other items, modifications were made with an expectation that clinician behaviour would change over time – say, one to two years. Examples exist in oncology and sleep medicine where hypofractionated radiotherapy and home versus laboratory sleep studies item modifications (respectively) were intended to influence behaviour over time. A continuous review will be instrumental in following these behaviour changes and ensuring the intended result is achieved. Implicit in this is a need to monitor unintended consequences, particularly those that might undermine the intent of changes made or undermine quality of care.

The need for a continuous MBS review mechanism to complement MSAC

A continuous MBS review mechanism ideally would complement the HTA work currently undertaken by the MSAC. It would identify new areas of need or areas where clinical practice is rapidly evolving, such as the orthopaedics example cited above.

It could identify priority areas where targeted research, investment or support is needed which would enable more streamlined assessment processes for the thousands of items currently on the schedule. This would deliver improvements for patients at a faster rate given the average MSAC process takes two years from receipt of application to decision on a single item. A key success of the MBS Review has been the ability to harness the clinical experience of more than 700 clinicians and health professionals and translate their recommendations into reforms in a relatively shorter timeframe.

The Taskforce carried out an item-by-item, specialty-by-specialty level review. It recognises a continuous review process, in addition to this, would necessarily broaden the approach. For example, future reviews might occur comparatively on all cross-specialty items used within a disease area. Greater use of cost-effectiveness, cost-utility and cost-minimisation analyses could be employed as necessary. It is expected the continuous review will complement the Government's integrity and compliance with regard to examining utilisation patterns and whether items are appropriate to intended functions or behaviour.

The model could assess and recommend improved treatments and care based on evidence, working with stakeholders or sector representatives for clinical expertise and analysis, and independent health economists to assess and report on the value proposition and costing of revised service items. Existing and new pathways for assessment, review and other advice would need to be clearly defined in the proposed model. This would provide transparency and assurance and retain Australia's highly regarded HTA pathways.

Stakeholders would rely on the certainty of a pathway as the most appropriate means to get an item added to the schedule. The framework would need to be carefully designed to provide stakeholders with clarity about the most appropriate pathway to use.

The Terms of Reference set for the Taskforce (Appendix 1) includes the requirement to advise on a structure for continuous review of the MBS. This advice is set out below.

Recommendation 20

As a matter of urgency, establish a continuous review mechanism to ensure the MBS remains contemporary and responsive.

This continuous review mechanism could exist as a single entity functioning in parallel with MSAC. However, it is the Taskforce's view that a new entity — a Medicare Advisory Committee — could bring together both the role of MSAC in examining new items and the role of a continuous review mechanism in reviewing, updating and removing existing items, and providing advice to the Minister on issues as required.

Recommendation 21

Establish a Medicare Advisory Committee (MAC) with Terms of Reference to include the current activities of MSAC with an enhanced focus on continuous review and the capacity to provide specific advice for the Minister.

The key to the success of the 2015–2020 Review has been the clinical accountability at its heart. The MAC should draw on a broader range of clinical, health economic and consumer expertise to inform its decisions, with overall responsibility for evaluating new applications and reviewing existing items to replace or delete items. The MAC would also act as a source of advice for the Government on clinical and system wide issues that arise from time to time.

Like the MBS Review Taskforce, the MAC would include clinicians from a range of disciplines, consumers, individuals with health policy and public health expertise. It would have the resources and ability to draw from clinical committees and working groups to harness the demonstrated benefit of clinician-led change.

The membership should include a range of healthcare providers, including specialists, GPs, nurses, midwives and allied health practitioners. It should also include people with diverse backgrounds which reflect modern Australia.

The MAC is not an additional advisory body. Instead, it will draw together the benefits of both the MBS Review and the MSAC to create a new body, which streamlines advice to Government about which items should be updated, removed or added to the MBS, and other matters pertaining to Medicare. This advice may extend beyond the MBS schedule to ensure the Minister is able to respond to developments in research and more advanced treatments to meet the health needs of Australians in the 21st century.

What will a continuous review do?

By introducing a continuous review mechanism, the Government will support an MBS that:

- assures the highest standards and quality of patient care and safety
- provides oversight and assurance of taxpayers' multi-billion dollar investment
- continuously, critically assesses the schedule to ensure it reflects the latest evidence, promotes best practice and supports quality care
- ensures reforms deliver a quality system that is sustainable and flexible
- collaborates closely with the medical profession, consumers and other key stakeholders
- articulates pathways for review of existing and new services, removing sector uncertainty delivering better healthcare for patients

The continuous review will serve as a mechanism for the continuous monitoring of changes, including those addressed through the current Review allowing the opportunity to identify any inadvertent perverse outcomes the recommendations have had on the sector and to patient care, access and affordability.

This approach will maintain a quality improvement cycle that decreases the lag time between new evidence and their translation into new treatments and care.

Building a sustainable, continuous review mechanism

The Taskforce recommends the MAC be supported by a set of principles to ensure public transparency and confidence in its actions. It should consider its stakeholders and partners and work to complement existing principles, processes and systems. It should incorporate lessons learned from the MBS Review along with expertise from HTR processes (See Appendix 4).

These considerations will be key to further inform the establishment of:

- governance – statutory nature and regulatory powers, structures, roles and functions, guiding principles, strategic priorities, outcomes and objectives
- assessment/evaluation and prioritisation requirements and modelling processes
- committees and membership
- a transitional work-plan

The work of the Taskforce has provided insights into the opportunities, risks and benefits for the Government in considering the future review needs of the MBS. It is important these are further developed to ensure the MBS remains contemporary, fiscally sustainable and responsive to changes in evidence and practice to deliver quality outcomes for all Australians.

Principles

A timely systematic process for continuous review of the MBS schedule is essential to ensure that the schedule remains up to date and allows for items to be added, amended or removed, so that care for consumers is in accordance with best practice.

The ongoing review process should be based on agreed principles to deliver high value care, align with contemporary clinical evidence, represent best value for money and improve health outcomes for consumers.

The continuous improvement process must be:

- Inclusive: led by clinicians and fully engages consumers and stakeholders
- Timely: considers key changes in practice as soon as practicable and ensures that all items on the MBS are reviewed at least once every 10 years
- Adaptable and flexible: ensures that reimbursement policies and assessments are as innovative as the technology and services they assess
- Equitable: considers the needs of consumers who have limited access to healthcare due to cultural, geographic, social or other reasons
- Efficient: minimises administrative and financial requirements for MBS management
- Transparent and accountable: instils confidence that process is fair and consistent and subject to public scrutiny
- Robust: remains relevant and useful in a changing health and political environment
- Effective: delivers improvements which can be easily understood by consumers and providers

Composition

Committee/working group membership should be multi-professional including experts in, for example, health services research, economics, ethics, epidemiology, biostatistics, and patient/community representatives when required.

Triggers for Review

The Taskforce envisages all MBS items would be classified with a set 'review by date' by which they must be reviewed. It would have a set requirement that 10 years should be the longest time frame between each item being reviewed, with some items likely to be reviewed multiple times in that period.

Decisions on which and how existing technologies (or groups) will be reviewed earlier could be considered via a series of triggers, including:

- Items already identified via the Taskforce
- An evaluation of the impact to related items as a result of changes made by the Review
- Areas of substantial growth in medical activity, decline or variability claims, where these patterns may indicate emerging low-value care
- The introduction of new items via the MSAC, which may change how existing items should be appropriately claimed
- Reviews of services within disease or medical condition pathways rather than by specialty group where possible
- Cases of inappropriate practice identified by the PSR, the Commission, or other quality assurance agencies
- Changes in the evidence base affecting items or item groups, including the development of new clinical guidelines
- Issues proactively raised by consumers or other stakeholders
- Clinician and industry compliance with the current rules and regulations already in place
- Consultations with clinicians about the pace of change in clinical practice.

Conclusion

This Final Report of the MBS Review Taskforce marks a critical point in the MBS's continued capacity to meet the future challenges of providing universal healthcare to Australians. Driven largely by changes in consumer needs and expectations, technology, and increasing costs that will see MBS spending exceed $30 billion per annum from 2022-23 (1), these challenges are unprecedented. Today's MBS, as good as it is by international standards, is ill-equipped to deal with them. Some change has begun, with many of the Taskforce's recommendations already implemented by the Government over the past five years. Further reform is needed – and needed now.

The Review reaffirms the intent and integrity of the MBS as a cornerstone of the Australian health system, supporting accessible and affordable healthcare. It locks in the foundational principles of Medicare, emphasising the system will always be about service to consumers, rather than provider convenience. It maintains the nation's GPs at the centre of patient care, recognising that a strong relationship between patient and GP is at the core of the health system. It recognises unequivocally that good GP stewardship is fundamental to the patient health journey and must continue to be supported.

The Review recommends the collection of, reflection on and the sharing of data to support evidence-based and data-driven clinical care. This would also support auditing, benchmarking and monitoring of care outcomes and identify low value care services as well as supporting service planning and resource allocation.

The Review also charts future directions for the MBS that will make it stronger, safer and sustainable. The Taskforce makes more than 1,400 recommendations to both consolidate and enhance the MBS as a key mechanism in universal healthcare. These recommendations are designed to set the MBS up for generations to come.

Crucially, the Review identifies the need for significant continuous review and reform of the MBS, with every item to be reviewed at least once every 10 years. Ongoing rigorous and comprehensive review and analysis will be essential in building a consistent, clear and more evidence-based MBS that works for patients and health professionals alike, providing optimum value in the broadest sense.

The Taskforce has viewed the MBS through a wide lens that extends beyond adding, amending, removing, and updating items and services, but also focuses on broader issues both inside and outside the MBS. These include MBS-wide structural issues and future payment models.

Implementing such reforms will need careful work and in many cases significant investment – but without them, the system will not be in a position to provide to Australians the care needed now and into the future, as the population ages, costs spiral, and complexity of illness and treatment grows.

This Review is by far the most comprehensive since Medicare's inception in 1984 and the Taskforce welcomes the Minister's commitment to consider every one of its recommendations. It notes that the Government has already accepted many of the more than 1,400 recommendations made during the past five years.

The Taskforce trusts that further implementation of the recommendations in this final report will cement the MBS's role as an essential component of Medicare, providing modern, safe and value for money healthcare to all Australians, now and into the future.

Where to Find More Information

The MBS Review Taskforce Reports are available on the Department of Health Website.

Acronyms

ABS	Australian Bureau of Statistics
ACSQHC	Australian Commission on Safety and Quality in Healthcare
AMA	Australian Medical Association
CDS	Clinical Decision Support
CQR	Clinical Quality Registry
CT	Computed Tomography
EMSN	Extended Medicare Safety Net
GDP	Gross domestic product
GP	General practitioner
HTA	Health Technology Assessment
HTR	Health Technology Reassessment
MAC	Medicare Advisory Committee
MBS	Medicare Benefits Schedule
MRFF	Medical Research Future Fund
MRI	Magnetic Resonance Imaging
MSAC	Medical Services Advisory Committee
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NIHR	National Institute for Health Research
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
OLSC	Office of the Legal Services Commissioner
OMSN	Original Medicare Safety Net
OOP	Out-of-pocket
PARC	Principles and Rules Committee
PBS	Pharmaceutical Benefits Scheme
PCOR-Vic	Prostate Cancer Outcome Registry-Victoria
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
PSR	Professional Services Review Agency
RACGP	Royal Australian College of General Practitioners
VHI	Voluntary health insurance
VPE	Voluntary Patient Enrolment
WHO	World Health Organisation

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Appendix 1: Medicare Benefits Scheme Review Taskforce Terms of Reference 2015

Purpose and structure

An expert, clinician-led Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) will lead an accelerated review of MBS funded services with contemporary clinical evidence and improve health outcomes for patients.

The Taskforce may appoint chairs and members of clinical committees and working groups to progress this work including clinicians, researchers, health technology assessment experts, health economists and consumers as appropriate to the issue.

Roles and responsibilities

The Taskforce will undertake the following:

- Review MBS items taking account of factors including concerns about safety, clinically unnecessary service provision and accepted clinical guidelines
- Commission evidence-based reviews that rely on assessment of literature and data
- Provide advice to the Minister for Health, including advice on the evidence for services, appropriateness, best practice options, levels and frequency of support through the MBS.
- Advise on a structure for continuous review of the MBS
- Advise the Department of Health on a Departmental program of work that aims to update the Act and regulations (MBS Rules) that underpin MBS funding
- Provide advice about the MBS and related health financing issues, including where the MBS funding model may not be the appropriate mechanism for providing patients with access to optimal care, as requested by the Minister
- Engage with health consumers, medical professionals, peak bodies and other stakeholders to seek their views about appropriate review approaches and processes

Constitution

The Taskforce will comprise:

- An independent, clinical Chairperson
- skills-based members, with a range of clinical and health delivery expertise, health technology assessment, health economics and consumers
- an ex-officio medical adviser (department member)

The Taskforce may nominate Observers and invite experts on an as needed basis.

Membership may be reviewed by the Department of Health, as agreed by the Minister for Health, on the basis of emerging issues or changing needs.

The Taskforce clinical committees and working groups will provide objective and robust advice and members will indicate all real, apparent and potential conflicts of interest.

Members of the Taskforce, clinical committees and working groups will observe confidentiality requirements.

The Taskforce will be a Departmental non-statutory committee, managed according to the Department's External Committee Framework.

Appendix 2: The History of Medicare

What is Medicare and the MBS?

Medicare is a key pillar of Australia's universal healthcare system. In conjunction with the Pharmaceutical Benefits Scheme (PBS), various joint and state-based public health, community health and preventive services, as well as a subsidised private health insurance market, Australian's have publicly subsidised access to a world-class healthcare system.

The MBS is a component of the Medicare program that (as at 1 August 2020) lists more than 6,000 eligible private medical services for which subsidies are provided to patients. Subsidies for clinically relevant services provided by MBS-eligible health professionals (mainly medical practitioners) take the form of 'Medicare benefits' paid to the patient. The MBS sets out the 'Schedule fee' for each service and the rate at which the benefit is to be calculated, as well as providing guidance on the clinical and administrative circumstances under which benefits can be claimed. The rates that benefits can be paid are:

- 75 per cent of the Schedule fee for in-hospital services for private patients
- The full Schedule fee for GP services
- 85 per cent of the Schedule fee for other out-of-hospital services

The categories of services subsidised under the MBS are listed below:

- Consultation fees for doctors, both GPs and specialists
- Tests and examinations by doctors needed to treat illnesses, including X-rays and pathology tests
- Most surgical and other therapeutic procedures performed by doctors
- Eye tests performed by optometrists
- Some surgical procedures performed by approved dentists and specified dental care services for eligible children
- Specified items under the Cleft Lip and Palate Scheme
- Specified allied healthcare services for chronically ill people who are managed by their GP

Table 1: Benefit payable examples

In-hospital Service	GP Service	Out-of-hospital Service
Item 30310	Item 23	Item 82015
Partial or subtotal thyroidectomy	Professional attendance by a general practitioner at consulting rooms lasting less than 20 minutes	Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder or an eligible disability by an eligible psychologist
$823.60 Schedule Fee	$38.75 Schedule Fee	$102.85 Schedule Fee
$617.70 Benefit Payable	$38.75 Benefit Payable	$87.45 Benefit Payable
75 per cent	100 per cent	85 per cent

The majority of annual MBS expenditure and number of services subsidised relate to general practice, pathology and diagnostic imaging tests, and specialist consultations. Medicare does not cover private hospital fees, examinations for life insurance, superannuation or membership of a friendly society, vaccinations for overseas travel, overseas medical and hospital fees, or medical costs covered by another body (such as a compensation insurer). Routine foot care, long-term care,

medical services that are not clinically necessary, cosmetic surgery, dental treatment[8], ambulance services, home nursing, physiotherapy, occupational therapy, speech therapy, chiropractic and podiatry services, treatment by psychologists (unless referred via a GP under an eligible program), visual and hearing aids and prostheses also are not covered. Some of these items, however, are covered by private health insurance funds.

The Schedule fee is a fee-for-service set by Government and may differ from the health professional's actual fee which they are free to determine. If they choose to charge an amount equal to the Medicare rebate, Medicare will pay the benefit directly to the doctor (referred to as 'bulk-billing'). If the health professional charges more than the rebate amount, their patient must pay the difference, typically referred to as an out-of-pocket cost or 'gap'.

The Medicare Safety Net is intended to assist people with out-of-pocket costs for Medicare-funded out-of-hospital services. The Original Medicare Safety Net (OMSN) was introduced in 1984 and increases the Medicare benefit from 85 per cent to 100 per cent of the Schedule fee once a threshold, indexed annually, is reached. Only the gap counts towards the threshold. The Extended Medicare Safety Net (EMSN) was introduced in 2004 and provides an additional benefit once certain thresholds are reached. In this case it is out-of-pocket costs—the difference between the Medicare benefit and what the doctor actually charges—which count towards the threshold. Once the threshold is reached in a year, Medicare will pay up to 80 per cent of any future out-of-pocket costs for Medicare services for the remainder of the calendar year. EMSN benefits are paid in addition to the standard MBS benefit.

Patient choice is a core principle under Medicare. Individuals are free to choose which GP they wish to consult, restricted only by availability. However, a referral from a GP is required before consulting a specialist physician or surgeon. Some specialists will refer to other treating specialists, depending on the clinical circumstances and complex needs of a patient. Patients may consult more than one GP, since there is no requirement to enrol with only one practice, and can also exert a choice over the referral made by their GP to a specialist or to a hospital.

When a patient requires hospital care, individuals eligible for Medicare can elect to be treated as a public or private patient. Treatment is free of charge in a public hospital as a public patient by doctors and specialists nominated by the hospital. Treatment as a private patient in a public or private hospital allows a choice of doctor. For private patients in private hospitals, Medicare will meet 75 per cent of the schedule fee for medical services provided in hospital, with part or all of the balance being claimable from private health insurers, subject to the doctor having a contract with the insurer. The costs of hospital accommodation are not reimbursable by Medicare when treated as a private patient but may be claimed through private health insurance.

The path to Medicare

As with many countries around the world seeking the benefits of universal healthcare for their citizens—especially those with federated governments like in Australia—the introduction of Medicare followed extensive debate. Up until the mid-20th century, if people wanted access to healthcare, they generally had to pay for it themselves or take out voluntary health insurance (VHI) from 'friendly societies' who also offered their members a range of benefits, including unemployment benefits and sick pay. The intention of Medicare was to fund healthcare costs for all through a national scheme that was equitable, universal and cost efficient (4).

The Government attempted to increase its role in social services following the Second World War. In the health sector, it established a Repatriation Commission that allowed the Government to pay for the care of returned soldiers through repatriation hospitals in each State (46). The Government at the

8 Except for eligible children under the Child Dental Benefits Scheme (CDBS) and the Cleft Lip and Cleft Palate Scheme.

time also attempted to introduce invalid, maternity and retirement benefits as part of the post-war social services movement. However, these attempts were not successful.

The proposed health sector reforms were met with strong resistance from doctors, conservative political parties and the voluntary insurance funds that they would lead to socialised medicine given what was happening in the United Kingdom with the development of the NHS (46). The social services reforms of the 1940s cumulated in a referendum in 1946 that led to a new section in the Constitution enabling the Commonwealth to make laws with respect to "*the provision of maternity allowances, widows pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances"* (47).

Even with new powers to fund medical benefits, the Government was unable to overcome stakeholder resistance to their reforms, other than to increase funding of state-owned public hospitals under the *Hospital Benefits Act 1945* and the reintroduction of the PBS under the *Pharmaceutical Benefits Act 1947*.

A change in government in 1949 led to further support of the VHI industry via the *Page Scheme* of 1952–53 and its regulation under the *National Health Act 1953* and *Medical Benefits Scheme 1953* (48). These changes established fee-for-service payments for medical and hospital services, and subsidised the operations of the VHI industry through the payment of Commonwealth benefits, tax deductibility for contributions and Commonwealth underwriting of the claims of the chronically ill and those with pre-existing conditions. Under the scheme, pensioners paid concessional rates, those meeting a means test had access to free treatment in public wards by honorary specialists, and VHI coverage increased to 83 per cent of the population in 1953.

By the late 1960s questions were being raised about the high cost, high reserves and limited coverage of VHI funds. There was also a view that, on a per capita basis, the total cost of the Australian health system exceeded by a large margin the cost of the NHS at the time. This was hard to prove, however, with little reliable data on patient out-of-pocket costs (12). The 1969 *Nimmo Commonwealth Committee of Inquiry* and 1970 *Senate Select Committee on Medical and Hospital Costs*, highlighted the system was unnecessarily complex with confusion about prices and entitlements, with many people being under insured (49)(50).

With the election of the Whitlam government in 1972, the Labor party moved away from previous ideas to expand state public hospital systems to compete with private hospitals and private doctors and adopted the Medibank scheme originally developed by Deeble and Scotton[9]. Medibank was about financing public access to the health system, not about how the health system itself could deliver services to the community. Its primary aim was to improve the equity of access to the healthcare system. It aimed to achieve this by extending to the whole population, basic levels of financial protection from healthcare costs and access to a defined range of hospital and medical services. Importantly, it would distribute the costs of such health services in accordance with capacity to pay (51).

The universal, compulsory, tax funded[10] national health insurance scheme was introduced into Parliament in 1973 but was met with strong opposition from the medical profession, private health insurers and opposition political parties, and was rejected by the Senate in 1973 and 1974. Some argued Medibank payments made directly to providers (rather than indirectly through health benefits paid to VHI funds) would make providers de facto Commonwealth employees, that it represented creeping socialism and that doctors would lose their independence (52). The legislation only

9 John Deeble and Richard Scotton co-authored proposals for Medibank whilst at the Institute of Applied Economic Research at the University of Melbourne in the late 1960s, later becoming policy advisors to the Whitlam government.

10 Although Medibank was originally to be funded through a taxpayer levy of 1.35 per cent on taxable income, with exemptions for low income earners, this never passed, and Medibank was funded via Consolidated Revenue when it commenced in July 1975.

passed after a double dissolution election and was introduced in 1975 with the Health Insurance Commission to administer the scheme under the *Health Insurance Act 1973*.

A change in government in 1975 resulted in a series of changes being made to Medibank from 1976 to support private health insurers. The introduction of the public insurance scheme meant that private medical insurance businesses ceased and the number of hospital insurance policies reduced by over 15 per cent since being introduced (53). Key changes were that individuals could opt out of Medibank and purchase private health insurance, while a levy of 2.5 per cent of taxable income was introduced for those people who chose to remain in the scheme. By then, a significant proportion of the population was effectively uninsured for public hospital treatment (46).

In 1983, the national public insurance scheme, Medicare, was introduced. The principles of Medicare were similar to those of the Medibank of 1975. Two principles that differentiated it were that it was to be substantially self-funding through a one per cent levy and a rearrangement of existing health insurance subsidies, and that the arrangements for reimbursing the States represented a fair reimbursement of revenue that was lost through removal of public hospital charges (2). Medicare commenced on 1 February 1984, following the passage of the *Health Legislation Amendment Act 1983* and related legislation in September 1983.

Medicare was a major reform at the time. It overcame political and stakeholder dissent to create a public health benefits system built around three key principles that embody a health insurance system viewed globally as 'simple, fair and affordable.' The following provides a summary from how these principles were adopted from Medibank in 1973 (2), presented to the public in the 1983 Federal Election campaign as the 'Hayden Health Plan' (54), and in Medicare in 1984 (4):

- **Social equity –** The scheme is to be equitably financed based on an individual's capacity to pay linked to their income. This is achieved via the Medicare levy and Australia's progressive income tax scales
- **Universal coverage –** Universality of coverage and eligibility of the scheme to all
- **Cost efficiency –** The government has a clear duty, as the custodian of public funds, to ensure that taxpayers get the best value in terms of health services for the money they contribute. This, in turn, means a duty to see that money is not wasted on an inefficient system of health insurance and that the maximum number of health dollars are spent on delivering services rather than administering the system

Appendix 3: Drivers of healthcare need and expenditure

Although the most cited driver of healthcare needs and expenditure is a demographic one – population ageing – it is generally not viewed as the most significant. Rather it is because this is also combined with other non-demographic drivers including the impact of chronic disease, economic growth and the resulting increase in incomes and consumer expectations, medical progress through innovation and new technologies, as well as higher relative prices of inputs such as wages. Expenditure growth can also be influenced by how we pay for services (funding mechanisms or payment methods) which can impact the allocative efficiency and integration (provider expectations) of the system.

Due to improvements in health, education and public safety, average life expectancy in Australia has increased. For example, the Australian Bureau of Statistics (ABS) notes in 2013 only 14 per cent of the population was aged 65 and over, with two per cent over 85. By 2063, this proportion is forecast to increase to 23 per cent and five per cent respectively (55).

Population ageing poses a challenge for governments, particularly in the financing of healthcare services because trends reveal a higher consumption of services and higher costs associated with older age groups (56). Based on current demographic forecasts, ageing is expected to account for around 10 per cent of increased health expenditure over the next four decades (59). Increased costs will also come at a time when fiscal resources will be under pressure from an increasing dependency ratio[11], with the quantum of potential tax payers expected to decrease by 15 percentage points by 2063 compared with 2013 (55). Current estimates predict that lost tax revenue and additional government expenditure associated with ageing will be equivalent to forecasted MBS expenditure in 2028–29 (58).

Chronic disease is a significant problem in Australia, with it being reported as the leading cause of illness, disability and mortality, contributing to 90 per cent of all deaths in 2011 (59). Further, growth in the prevalence and costs of chronic disease suggests that the problem is worsening (9).

Although the rate at which chronic disease contributes to the burden of disease has grown slower than other diseases, it appears that more effective treatments come at a higher cost. Chronic conditions are also occurring earlier in life and Australians may live for longer with complex care needs. This means individuals require more services from a range of providers across the health system over extended periods of time (60). Based on current risk factor trends (61), it is reasonable to assume more resources will be required for prevention or to treat chronic disease into the future and this will continue to be a driver of expenditure unless health risks are effectively dealt with.

In many Organisation for Economic Co-operation and Development (OECD) countries (including Australia) it has been observed that as national per capita gross domestic product (GDP) increases (often cited as a proxy for income), the population tends to have higher expectations of health service providers and place more demands on the health system generally. As incomes rise and expectations grow, governments (in their role as funders and regulators) and health service providers (both public and private sector) often respond to these demands by funding new treatments or by extending the scope, range, and quality of existing treatments.

11 According to the ABS the total dependency ratio is a measure used to compare the size of the dependent population to the working age population. It is calculated by combining the youth population (0 to 14 years) and senior population (65 and over) then dividing this by the working-age population (15 to 64 years) and multiplying it by 100. It is expressed as the number of 'dependents' for every 100 'workers'.

Australia, for instance, has experienced continuous economic growth for the past 26 years. During this time annual growth in total health expenditure has exceeded annual growth in GDP per capita. This is a trend likely to continue, with a 2016 study by the World Health Organisation (WHO) concluding that policy-makers should not expect costs to rise less than the growth in GDP (62). A recent analysis of OECD countries indicates (63) that higher incomes and increased consumer expectations contribute to approximately 40 per cent of the growth in health expenditure.

Another key driver of health expenditure is new technology such as robotic surgery and higher resolution medical imaging. The Government cannot support every new technology, so it directs funding to technologies that are both clinically and cost effective. Some technologies lower costs – for instance by reducing hospitalisations – while others drive total costs up by extending the scope, range and quality of available medical services. Overall, the literature suggests that technology accounted for approximately 30–50 per cent of the growth in costs between 1960 and 1990 (64).

Labour is a significant component of health and aged care services because human interaction is vital, and the automation of care is difficult. In many industries, technology allows labour to be reduced and savings to be passed on as wage increases. But for the health sector, it is human input that is valued and cutting labour often means cutting services, access or quality. As a result, wages in the health and aged care sector must keep pace with other parts of the economy.

For example, in Australia between 1997-98 and 2015-16, wages in healthcare and social assistance increased at 3.5 per cent per annum – above the average for the general economy and above inflation (65). With wages accounting for about two-thirds of Australia's recurrent spending on healthcare (66), it is reasonable to assume wage growth will continue to be a driver of health expenditure in the future, especially with continued growth in the number of health professionals.

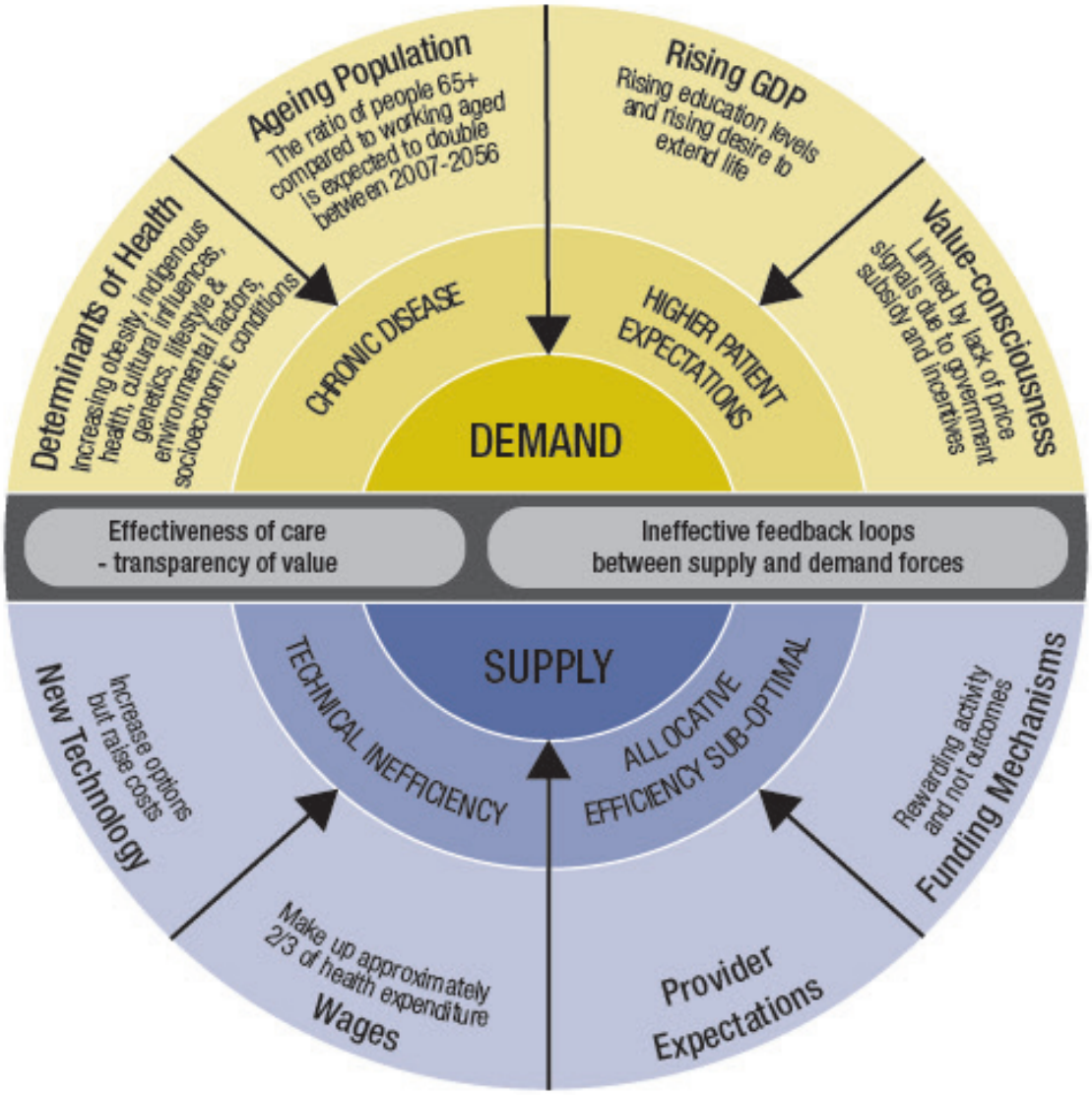
It is also generally accepted that a cause of the fiscal sustainability problem for funders of healthcare systems can be related to the growth in the volume and underlying complexity of services delivered (67). Payments for services or products should generally reflect short-term performance or long term value, yet payments in healthcare systems have often simply rewarded greater volume of services whether they are needed or not. A key driver of this growth relates to the continued prevalence of payment methods used by funders that reward volume rather than valued outcomes ('value').

The prevalence of volume-based payment methods has influenced business practices (provider expectations) and increased overall system costs by allowing providers to increase revenues by delivering more services without necessarily improving clinical or patient-reported outcomes.

Volume-based payment methods can also result in perverse outcomes, such as indirectly penalising providers for keeping people healthy, reducing errors, decreasing activity due to increasing prevention and avoiding unnecessary or low-value care. Incentives created by the payment methods and the responses of providers to those incentives, management information systems to support payment methods, and accountability mechanisms established between providers and payers can have profound effects on the way in which resources are allocated and services delivered.

Figure 5 illustrates how the aforementioned demand and supply side factors combine to put pressure on healthcare expenditure. It is this interaction of the different factors, rather than any one single factor, that makes it such a challenge to manage the quantum of expenditure in a fiscally sustainable manner. These pressures are further exacerbated by a complex and fragmented system that lacks outcome transparency and inhibits normal market forces that usually regulate efficient supply and demand.

Figure 5: Drivers of health care expenditure



Appendix 4: Health Technology Reassessment Process

The term 'Health Technology Reassessment' (HTR) defines a structured process involving an evidence-based assessment of the clinical, social, ethical and economic effects of a technology[12] currently used in the healthcare system. This process would inform decision makers about the technology's optimal use and value in comparison to its alternatives throughout its life cycle (68) (69) (70) (71).

The process is a top-down approach to actively assess the effectiveness of low-value technology, with other considerations such as attrition, empowering clinicians, increasing transparency and clinical redesign, generally incorporated to broaden its effectiveness. The outcome is a change in scope-of-use of the technology, its removal from practice, or no change in use.

HTR differs from existing MSAC processes, referred to as a 'Health Technology Assessment', as it generally advises the Health Minister on whether *new* technologies should be publicly subsidised based on evidence of their comparative safety, clinical effectiveness, cost-effectiveness and total cost. The principles and methods used by MSAC are similar, however, HTR methodologies also require consideration of the perspective of diverse users and recipients to account for the fact the technologies are currently in use (72).

A study of literature between 1990 and 2014 highlighted no single taxonomy to describe HTR approaches (73). For example, removing low-value services from practice is commonly referred to as 'disinvestment', however, the less cited term of 'de-adoption' is preferable. The term disinvestment can be highly charged as it represents removing its subsidy, whereas de-adoption better reflects the decision to discontinue an existing intervention after it is no longer cost effective in comparison to alternatives. The following differentiates the commonly used terminology (68):

- **Disinvestment:** Completely or partially withdrawing healthcare resources from currently funded areas that provide little benefit for their cost. Disinvestment can lead to full or partial withdrawal of a technology, contractual variation, restriction, or substitution and employs financial disincentives
- **De-implementation:** Where the use of low-value care is reduced or stopped on a structural basis in a planned process that uses a set of activities, which can include financial disincentives, but also uses other activities such as data feedback, education, and system interventions
- **De-adoption:** The discontinuation or rejection of a clinical practice after it was previously adopted

The HTR process is still an emerging field internationally, with most activity associated with tasks undertaken by existing HTA bodies. A recent review (73) of nine countries identified only four UK (the National Institute for Health and Care Excellence), France (the Haute Autorité de santé), Australia (the Pharmaceutical Benefits Advisory Committee and MSAC), and Spain (the Basque Office for Health Technology Assessment and the Unidade de Asesoramento Científico-técnico) — that had some form of established process to support HTR. Of these, only France conducts a regular review of publicly funded technologies to form the basis for a potential HTR. The other three only conduct reviews when requested by authorities. The remaining five countries — Canada (Canadian Agency for Drugs and Technologies in Health and the Institut national d'excellence en santé et en services sociaux), US (Institute for Clinical and Economic Review and the Agency for Healthcare Research and Quality), Germany (the Federal Joint Committee G-BA), New Zealand (the Pharmaceutical Management Agency) and Finland (the Finnish Medicines Agency) — had no formal frameworks.

12 Health technology is broadly defined as drugs, diagnostic tests, including indicators and reagents, devices, equipment and supplies, medical and surgical procedures, support systems, and organisational and managerial systems used across the spectrum of health care (78)

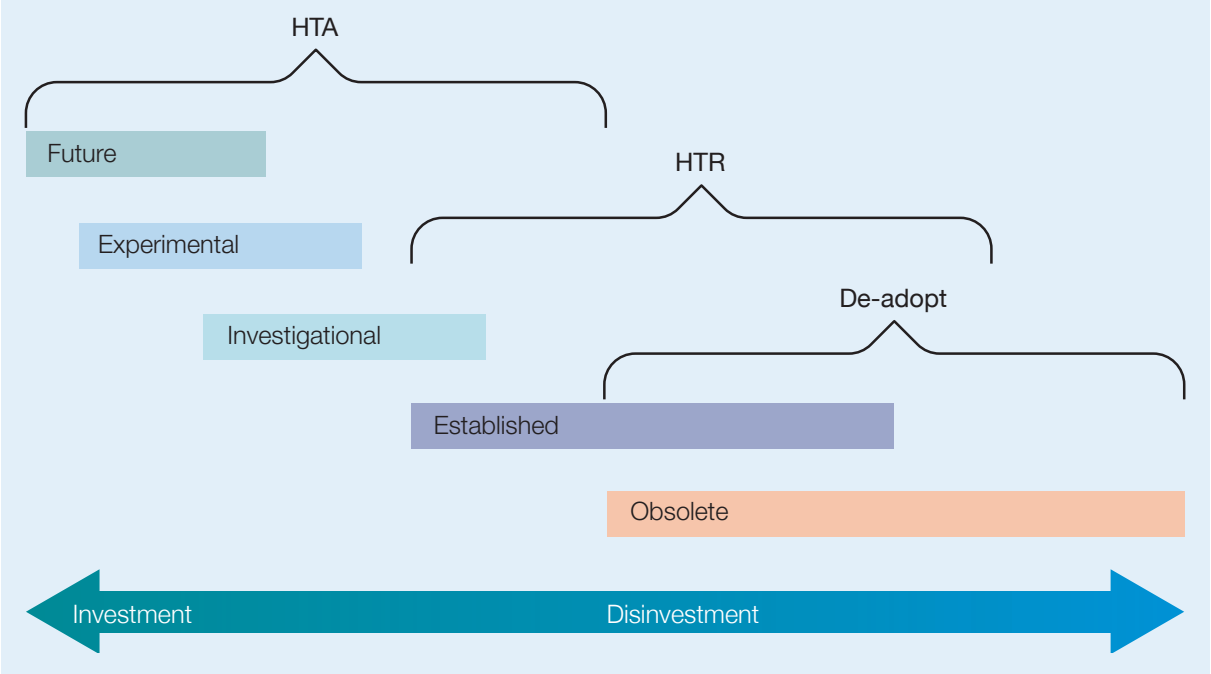
This role would be consistent with the original intent of Medicare to have a function that could work collaboratively with health institutions, the health professions, the states and with the public to understand the operations of the sector while working together towards a sustainable scheme (54).

As with all technologies, health technologies experience obsolescence as a part of their lifecycle. In the case of the health system, a technology is obsolete and thus low-value, if its clinical benefit, safety or cost-effectiveness has been significantly superseded by other available alternatives (75). In addition to obsolete technologies, low-value technologies can also be those considered ineffective or wasteful in certain circumstances, such as through overuse or when applied to particular patient types without material clinical benefit.

A well-functioning, structured HTR process that benefits from the lessons of the Review and is appropriately integrated with MSAC, would provide Australia with a world leading approach to managing health technologies throughout their lifecycle, rather than just at their adoption. This would provide the public and taxpayers with a transparent mechanism to continue improving patient care and system efficiency by identifying how best to reallocate resources away from low-value care towards high-value interventions and technologies.

It is important to note that the benefits of an effective HTR process can extend beyond simply disinvesting in obsolete technology. The process also aims to address the optimal or most effective, use of technology already in the system. Figure 6 depicts where HTR fits into the health technology life cycle as it is important to differentiate HTR from HTA, its various approaches, as well as the de-adoption and potential disinvestment steps.

Figure 6: Health Technology Life Cycle



The key to realising the benefits of an effective HTR process, like the MBS Review, is the ability to translate outputs and recommendations into practice. This 'translational' step is considered the most difficult task (66) (71) and has been a challenge for the Taskforce over the past five years. John Kotter identified that organisational transformation is notoriously difficult, with failure rates around 70 per cent (76). In healthcare, this change tends to be harder still with practitioners often viewing their work as a vocation as much as a profession, and are historically suspicious of agendas

that impact their business models. This will continue to be a vital consideration when designing and implementing the enduring review function.

Various barriers (68) will need special consideration in the design of the structured review function. These include issues such as the standard of evidence required, the climate, social and political context in which change is proposed, the impact of incentives on behaviour, and the role of stakeholders in providing leadership to break through provider resistance. The Taskforce is optimistic from anecdotal evidence suggesting generational change and the impact of changes in disease burden on work practices will increase sector buy-in to support change.

The Taskforce's experience to date has shown reviews will also continue to face many challenges in identifying what are low value technologies and overcoming the sector's strong incentives to retain existing ones, no matter their value. It is common that HTR has a greater success at change in cases where existing technologies fall into disfavour. In light of this, the future review function could incorporate other strategies to encourage change in medical practice (77):

- Working with the colleges, professional associations and the Commission to change provider information through the use of evidence-based clinical guidelines or via the results of practice variation studies. Guidelines attempt to change clinician behaviour by improving their knowledge, while promulgating information about medical practice variations attempts to change behaviour by peer comparison
- Changing incentives, through different payments for clinicians and other providers, or specifically targeted incentives
- Changing consumer behaviour by providing more information with or without financial incentives
- Incentivising changes to the structure of health service delivery to provide organisational support for more efficient care

Change can also be advantageous when HTR processes target services that present a quality or safety concern. Although somewhat difficult in today's data environment, robust evidence in these circumstances, rather than an emphasis on cost effectiveness, tends to allow for improved decision-making and method to engage clinicians with change.

Recommended structure of HTR processes

Recent studies (73)(71) have recommended effective HTR processes should be structured according to the following three-phased approach:

- **Phase one:** Identification and prioritisation
  - Identification involves determining which technology to review and the knowledge unit to measure its value to patients. This could be based on a randomised clinical trial, systematic review, and/or clinical practice guideline.
  - Prioritisation is required when there is more than one low-value technology identified. The process should be based on the strength of evidence supporting the lack of efficacy or safety (such as harmful practices eliminated first), potential health and cost impact of de-adoption, and availability of alternative practices.
  - As with the MBS Review, phase one activities should be completed in collaboration with stakeholders and can benefit from using information gathered from pre-existing lists of low-value care, through horizon scanning or data driven mechanisms as benchmarking, practice variations and CQR analysis.

- **Phase two:** Evidence-based decisions and policy development
  - A broad evidence synthesis, including barriers, using streamlined methods primarily from HTA to determine the clinical, economic, ethical and social effects of the technology being reassessed. This will include a comparison of alternative technologies and should be coordinated with MSAC should new technologies be in the pipeline.
  - A policy or practice recommendation is generated based on the evidence and stakeholder input, with an output to increase its utilisation or adoption, a decrease in utilisation, no change in utilisation, or withdrawing the technology completely.
  - This step was difficult during the Review with limited data being available on current practices as noted earlier in the report.
- **Phase three:** Policy implementation, monitoring and evaluation
  - The implementation of the policy or practice recommendation followed by monitoring and evaluation. Evaluation will need to measure whether there is continued use, the cost impacts of change and any potential harms caused. It is critical to involve the clinicians who use the items in this process.
  - At the end of this phase it is necessary to assess whether the desired change was achieved or not. Any de-adoption intervention should include a sustainability plan or it is highly likely that healthcare providers will (knowingly or unknowingly) revert to using the practice to which they have become accustomed.

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