

# Medicare Benefits Schedule Review Taskforce

## Taskforce Findings

### Consumer Panel

## Report

This document outlines the Medicare Benefits Schedule (MBS) Review Taskforce’s recommendations in response to the report from the Consumer Panel.

The Taskforce endorsed four recommendations from the Final Report from the Consumer Panel and submitted them to the Minister for Health for Government consideration.

<b>Number of items reviewed</b>	n/a
<b>Number of recommendations made</b>	4

The Consumer Panel has reflected on the experience of its members on MBS Review committees; feedback from the survey of committee chairs and consumers; public consultation feedback; and current literature and evidence regarding partnering with consumers effectively in health policy, research, services and care. The following recommendations are the outcome of the Panel workshoping these varied sources of information and perspectives on consumer engagement.

### List of Taskforce Recommendations

#### Recommendation 1: Principles

##### Apply principle-based decision-making to build a consumer-centred MBS

One of the first outputs of the Consumer Panel was a set of principles to be applied in deliberations and decision-making to ensure a consumer-centred MBS. These Principles were endorsed by the Taskforce.

The Panel reiterates its recommendation (2016) that the following principles are applied and further developed in MBS Review deliberations and decision-making.

#### 1. The MBS Review, and ongoing MBS management is co-designed.

- Evidence-informed consumer engagement is integrated in the design, implementation, monitoring and evaluation of the MBS to ensure it meets the needs, values and preferences of consumers and the community\*, not just clinicians, industry and policy makers.

\*As per the definition of consumer-centred care outlined in Patient-centred care: Improving quality and safety through partnerships with patients and consumers. (6)

- 2. The MBS Review supports the development of an Australian health care system that is safe and high quality; provides equity of access and outcome for patients; delivers improvements in patient outcomes; supports the efficient and effective use of resources; and is sustainable.**
- 3. Design and use of MBS Items support safe, evidence-based, high quality consumer-centred care.**
  - MBS items with significant potential health impacts are linked to contemporary evidence.
  - The MBS allows sufficient flexibility to tailor treatments and care to the specific needs of individual patients, which may not align directly with Guidelines, but where the variation is well considered and appropriate.
- 4. Design and use of MBS Items support fair and equitable access and outcomes for all.**

For example:

  - Address geographic location as a barrier by proactively looking at scope of practice of more than one clinical group, and reimbursement for clinical services that reflects the cost of service provision in regional and remote settings
  - Ensure changes to the MBS do not drive an unreasonable increase in out-of-pocket expenses, particularly for vulnerable groups such as people with, or at risk of, multiple chronic diseases
- 5. The MBS ensures equity of access to medical services, regardless of whether it is provided in the public or private sector.**
- 6. MBS Review processes encompass assessment of individual and systemic health quality and economic benefit.**
  - Real out of pocket (OOP) expenses for consumers are calculated when determining (relative) Item costs; a total OOP is calculated where multiple services are associated with the condition being treated; and for long term conditions the OOP is calculated for a longer period and potentially for the entire patient journey.
  - Quality and economic benefit (or cost effectiveness) are two different things to be balanced one against the other, and not assessed as one parameter.
- 7. The MBS is a dynamic and responsive system that only funds services that improve health outcomes.**
  - This may require new systems of data collection and analysis and new ways of public reporting.
- 8. Use of MBS data is maximised for public benefit, and with appropriate governance to ensure that public benefit does not cause harm to the individual.**
  - Ongoing monitoring /post-market surveillance/data availability for research purposes is integrated into the use of the MBS to support evaluation and review for quality assurance.
- 9. Lack of evidence does not always mean that an item is not effective and should be removed. It does confirm the imperative for data collection and post market surveillance that can meaningfully track the appropriate use of MBS items.**
- 10. The MBS Review does not remove access to a service where it is appropriate for the care of a small, defined patient group.**
  - If necessary, the descriptor can be amended to ensure Item use is targeted to the appropriate patients, and only accessed by the appropriately trained clinicians.
- 11. Patient Reported (Adverse) Outcomes Measures (PR[A]OMs), Patient Reported Experience Measures (PREMS) and other quality of life measures are considered along with clinical outcomes measures when determining safety, quality, efficiency, efficacy, access and currency of MBS Items.**

## 12. Implementation of the MBS Review:

- Supports business practices that enable consumers to make fully informed decisions including clinical information and cost comparisons across public and private options.
- Inhibits listing of multiple Items for single consultations/treatments.
- Addresses conflict of interest and full disclosure regarding any recommended device/service.
- Uses the MBS to fund universal access to safe health care, particularly for the most vulnerable – and not simply convenience of access.
- Is reported upon publicly in ways that ensure clinicians and corporate beneficiaries of Medicare are accountable to consumers as patients and taxpayers.
- Is quality assured and incentivised through professional practice measures such as training.

### Additional considerations

The Panel also noted that:

- Further development of consumer principles is likely to include principles related to reporting, disclosure, transparency and regulatory oversight as well as communication and informed (financial) consent. *For example:*
  - Not every health service has a consumer cost reimbursement via the MBS
  - Practitioners that exploit the MBS are reported to the regulatory authority
  - Simplicity where possible in the MBS supports professional conduct – and identification and management of alleged unprofessional conduct.
- All practitioners in the MBS Review can be considered to have a Conflict Of Interest: this is inevitable. Genuine, structured and supported consumer feedback in Review reports is required to ensure the conflicts have been successfully managed as well as to ensure the recommendations work in the best interests of the consumers to whom the reimbursements will be paid.
- Principles and learnings from the MBS Review should be applied more broadly to future reviews in the public space, other government agencies or health technology processes.

### Recommendation 2: Practice

**The Consumer Panel Consumer Engagement Resource is used as a reference in future planning for ongoing review of the MBS.**

The Consumer Engagement Resource has a number of tools that could be further developed by and for all partners in any ongoing review of the MBS – and other health technologies. They include:

- Consumer recruitment, role and expectations
- Consumer principles to guide Review deliberations and decisions
- Examples of questions to focus consumer perspectives in reports
- Critical checkpoints for consumer engagement in the work of clinical committees
- Recommended approach to targeted public consultation
- Public communication checklist
- A consumer perspective on evidence

- Hints and tips for consumers on committees
- Support available to consumers and others on committees
- Consumer-related terminology
- Consumer engagement summary
- Consumer impact statement
- Consumer report i.e. summary table of recommendations and rationale.

### **Recommendation 3: Priorities**

#### **Consumer priorities and perspectives are key drivers of an ongoing MBS cycle of review.**

Consumer priorities and perspectives articulated in the MBS Review to date include:

1. **Value:** integrate person-centred determinants of value including:
  - a. Equity of access and outcome.
  - b. Contribution to holistic, integrated, coordinated health (and social) care.
  - c. Contribution to the person's health care goals.
  - d. Inclusive, acceptable, non-discriminatory practice.
  - e. Evidence to support the above.
2. **Appropriate Access:** 'Appropriate is defined as *'contributes to an improved health outcome'*.
3. **Principles and rules:** undertake a comprehensive, person-centred care review of MBS principles and rules.
4. **Informed consent and informed financial consent:** ensure these are explicitly described, required and audited for compliance.
5. **Patient reported outcomes measures (PROMs):** actively seek and promote development and use of these in applications, assessments and reviews.
6. **Health economics:** include consumer costs, including out of pocket costs, in health economic assessments; assess health and economic benefit and cost at a system and individual level, and also longitudinally as well as episodically.
7. **Integrated, coordinated care:** ensure items are not considered in isolation of the person's holistic care and their overall use of the MBS – and the Pharmaceutical Benefits Schedule (PBS).
8. **Futures focus:**
  - a. Maintain a futures focus with 'action items for the future' a standard component of every review report.
  - b. Considers elements of out-of-scope (but relevant) items, unintended consequences, workforce issues, effective data collection.
9. **Data:** address the consumer-related data gap through a data strategy that includes care pathways; patient reported outcome measures (PROMs); variations in access to care; people's motivations to take action for their health; social determinants and supply and demand.
10. **Workforce:** integrate considerations of, and proactive planning for, workforce issues related to MBS reform.

11. **Equipment:** incorporate considerations of equipment and other capital investment in the review process.
12. **Agility:** able to adapt and adjust successfully in the face of on-going and rapid technological change in healthcare ensuring inclusive consumer engagement. (9)
13. **Audit on recommendations:** including data, access, quality and unintended consequences.
14. **Transparency:** both organisational and consumer-centred transparency in treatment options, out-of-pocket costs, potential risks and realistic outcomes. (10)
15. **Structural Links between Health Systems:** creation of public policy that reflects stronger and better relationships between the various health-care delivery systems.

#### **RECOMMENDATION 4: PARTNERSHIP**

**A genuine, evidence-informed partnership between consumers, clinicians, researchers and policy-makers drives an ongoing MBS cycle of review.**

Considerations to achieve this include:

1. **Consumer Secretariat:** establish and resource a Consumer Secretariat whose role is specifically to support consumer engagement in MBS reform.
2. **Consumer engagement:** work with the Health Technology Assessment Consumer Consultative Committee to develop a systemic model of consumer engagement that includes communication with and feedback from targeted patient, consumer and community groups and the general public.
3. **Capacity building:** work with the Health Technology Assessment Consumer Consultative Committee to develop sustainable systems for public communications (including plain language public summary documents) and education sessions and tools for patient, consumer and community groups who have an interest in the MBS.
4. **Health literacy:** co-design tools for consumers and clinicians to support consumer health literacy in relation to consultations, tests and procedures. Include co-design shared decision-making/decision-support tools and processes and quality, accessible information, linking with Healthdirect as relevant.
5. **Practitioner audits:** co-design compliance priorities, processes and reporting and 'peer' supervision' instruments.
6. **Safety and quality:** coordinate schedules of work with the Australian Commission on Safety and Quality in Health Care, including development of clinical standards, partnering with consumers and patient reported outcomes (PROMs).
7. **Clinical registries:** develop a coordinated approach to the establishment, quality assurance and use of clinical registries including the use of patient reported outcomes.
8. **Quality assurance processes** - integrate these and include:
  - a. Co-designed standards, guidelines and professional and service accreditation.
  - b. Review cycles including reports of predicted and actuals.
9. **New and developing knowledge:** build on the findings of the Taskforce.
10. **Research:** establish a research agenda and partnerships with a focus on how person-centred care, including genuine informed consent, can drive individual and systemic value in health care.