Submission to the Medicare Benefits Schedule Review

November 2015

Key Points

The review is timely and needed

- The Consumers Health Forum of Australia (CHF) supports the Medicare Benefits Schedule (MBS) Review, particularly its primary objective of ensuring best patient health outcomes for MBS expenditure. The review is timely. Medicare was conceived well over 30 years ago when Australia's disease profile and population health challenges were different. The MBS itself has grown from 300 items to the current 5,700, with no review or delisting of those that pre-date MSAC's inception.

A modern, responsive MBS

- The review and, most importantly, the future design and architecture of the MBS should be geared around ensuring a modern MBS that provides the incentives and creates the conditions for the models of care required for best practice, multidisciplinary, coordinated chronic condition management. These are most likely to be new payment regimes, not fee-for-service. The same applies to preventive health care. Unnecessary redtape and workload for GPs, and most importantly, cost and inconvenience for consumers should be removed. This is particularly the case for annual renewal of referrals. The option for indefinite referral is not well understood or utilised by consumers and GPs. This fact needs to be more widely disseminated to all parties.

Consumer health literacy paramount

- Consumers and the wider community need to have a better understanding of what Medicare care is. CHF recommends a community awareness programme about Medicare and the MBS. We will get more judicious Medicare outlays when people are more engaged with their healthcare and healthcare choices through a greater appreciation of how much particular programmes and services cost.

Adding new items

- There needs to be greater clarity about the process that will be followed for logging and systematically appraising suggestions for new numbers. These will inevitably arise during the deliberations of the clinical reference groups. While out of scope of the review, we are also aware that many organisations are actively making the case for new items as part of their submissions.

Best practice health technology assessment

- Australia should aspire to and progressively implement best practice health technology assessment methods in relation to future MBS items. Our practices in this area should be continually reviewed and benchmarked against global practices in order to keep us on a continuous improvement trajectory. Consumers must have the ability to not only understand the MSAC process, but also to systematically participate in it.

Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with an interest in health consumer affairs. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF welcomes the opportunity to provide input to the MBS Taskforce process though this submission and welcomes the opportunity for consumers to have input into the more detailed reviews of the MBS items as the Review moves into the next phase of its work.

This Submission addresses the key issues identified in the discussion paper and has been informed by consultation across the CHF network of member organisations, individual members and consumer representatives. We have not included specific examples of MBS working/not working for individuals as we know many individuals have provided these directly to the Taskforce through submissions and through the consumer workshop CHF ran on 26 October.

Overall position

CHF supports the primary objectives for the Review as follows:

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

It is clear that a full systematic review of the MBS is overdue. Since its inception in 1984 the MBS has grown from listing approximately 300 items to currently listing 5,700 individual items. Few of the MBS items have been reviewed and tested to confirm, based upon clinical evidence, that they continue to be effective. The system seems designed for adding procedures but does not currently have adequate procedures in place for removing items from the MBS.

There have been some limited efforts to review components of the MBS but they have had limited success, in part because they have been rejected by key stakeholders and in part because they were confined to some key areas. The major opportunity from this review is that it will look at all items which means no groups should feel disadvantaged and consumers can have confidence that when the process is complete the treatments, tests and procedures they are offered will be based on sound evidence for effectiveness and safety.

There has been a technological revolution in medical care, in techniques, devices and treatment options and the MBS has not kept pace with these. Consumers often express frustration when they find that treatment options available internationally

are not funded in Australia and whilst most appreciate the need for the MSAC process to ensure safety and quality there is less understanding of the requirement to constrain expenditure. If the MBS was modernised and some items taken off then it would free up funding for new treatments to help keep pace with innovation.

Support for fee for service

CHF supports fee for service but this needs to be evidence based good quality service that drives good quality practice. Australia is affluent and, as an affluent country, Australia should be prepared to pay for such service and practice as it leads to a healthier community. Obviously the danger in a fee for service model is over servicing which could be a considerable cost to the community. Over servicing of particular items, however, does not necessarily mean that those items are not of benefit to some patients. There is a difference between those items that are of no benefit and those that may simply be over used by certain health practitioners.

Consumers need to have a better understanding of the MBS

A 2007 article in the Medical Journal of Australia, *Challenges in health and health care for Australia*, identified that:

> Public consultation and agreement about what a wealthy democracy such as Australia should provide for the health and health care of its citizens, and how the health system might be structured to achieve that provision, should take priority. The focus should be on the big picture.[1]

CHF endorses this statement and advocates for the health consumer having a better understanding of what the MBS is. In a 2011 paper, *Development of Long Term Consumer Engagement Strategies for the MBS*, CHF found that:

> The current MBS system is confusing and unclear to consumers. There is a lack of consumer-friendly information about the MBS and its processes. Consumers have reported difficulty accessing data on MBS usage and structure. Most consumers reported feeling confused about how the MBS system works and had little or no understanding of how items could be added or removed from the MBS.[2]

CHF and other healthcare consumer focused health advocacy organisations can be integral in providing, alongside government, education and information about the MBS to healthcare consumers. Such educative engagement with the community is particularly important for government in an increasingly connected – particularly via social media – world. Indeed, the importance of engagement with major segments of the community is underscored by an attempt to harmonise the processes for

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[1] Bruce K Armstrong, James A Gillespie, Stephen R Leeder, George L Rubin and Lesley M Russell, 'Challenges in health and health care for Australia' *Med J Aust* 2007; 187 (9): 485-489, p. 488 see https://www.mja.com.au/system/files/issues/187_09_051107/arm11047_fm.pdf viewed October 22 2015.

[2] Consumers Health Forum, *Development of Long Term Consumer Engagement Strategies for the MBS*, 2011, p. 3. See https://www.chf.org.au/pdfs/chf/Long-term-Consumer-Engagement-Strategies-for-the-MBS.pdf viewed 23 October 2015.

health products of Australia and New Zealand, which did not take place in part because:

> the concerns of the Maori community in New Zealand over the way that traditional medicines would be treated were not recognized at the outset. This, together with other political changes, led to loss of support for the process. There is a clear lesson here that failure to engage a major stake-holder at an early stage can lead to problems later on, if that stakeholder believes that important issues are not being addressed. [3]

Further, healthcare consumers being aware of how the healthcare they access is funded forms part of the push for greater health literacy. The Australian Commission on Safety and Quality in Healthcare (the Commission) describes health literacy as follows:

> Health literacy is about how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it.[4]

The Commission separates health literacy into two components: individual literacy and the health literacy environment. To improve consumer understanding of how the MBS operates and its implications for care the environment needs to be improved and the Departments of Health and Human Services need to look at how their role in improving the health literacy environment. They need to look at ways they can improve the way information on MBS is made available. This includes revising the materials available about the MBS to ensure they are more accessible. The MBS book needs to be rewritten in plain English, with fact sheets on key issues and a series of frequently asked questions and response that are easily accessible to consumers, on their own websites and look for ways to disseminate the information through healthcare consumer organisations such as CHF to reach out to consumers.

Healthcare consumers with a better understanding of the MBS will be more engaged with their healthcare through a greater appreciation for how much particular services cost. As the consultation paper states:

> Even when consumers do not face any out-of-pocket costs, they may want to understand the cost to Medicare of the service they have received.[5]

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[3] John Hutton, Paul Trueman and Karen Facey, 'Harmonization of evidence requirements for health technology assessment in remimbursement decision making' *International Journal of Technology Assessment in Health Care*, 24:4 (2008), 511–517, p. 514 see http://www.htai.org/index.php?eID=tx_nawsecuredl&u=0&g=0&t=1445573558&hash=39a967484551ff790a11b43610e7bfb1401bd68d&file=fileadmin/HTAi_Files/Policy_Forum_Public/IJTAHCHarmonizationOfEvidenceArticleSept2008.pdf viewed 22 October 2015.

[4] See http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/ viewed 22 October 2015.

[5] See http://www.health.gov.au/internet/main/publishing.nsf/Content/922CB2933B0F1645CA257EC1001D5C12/$File/MBS%20Review_Consultation%20paper_FINAL.pdf viewed 22 October 2015.

CHF believes that such an understanding makes for a more health literate Australian citizenship.

Treatment of new items onto MBS

Once this Review has been completed and the MBS has been modernised it is critical that the MBS not be left without a continual focus on keeping it modern. CHF supports the continued use of the MSAC process for new items to be added to the MBS, including those that emerge from this review process. As Stephen Duckett, Director of the Health Program at Grattan Institute, states

> It is fair and reasonable that public subsidy for treatments should be based on assessment of value. So it is right that the review checks whether the schedule has kept pace with changed knowledge and practice.[6]

It would be counter to the purpose of this Review if the items on the MBS were to be consolidated based upon clinical evidence and then future items were to be added to the MBS without going through the rigorous MSAC process so there should be no shortcuts included in the process. Making sure that additional items added to the MBS go through the MSAC process would be a mechanism for continual review of the MBS.

However there is a case to be made for the Review process to be able to amend current MBS items and not have to put those amendments through the MSAC process. There are already considerable time delays within the MSAC process and the additional workload associated with looking at amended MBS items would exacerbate that delay. The rigorous process being used for review in assessing available evidence means that the MSAC process is redundant.

CHF also recommends that there be a process of periodic review of existing items with a set of predetermined criteria to initiate a review to ensure the Schedule keeps up with technological change and innovation.

Consumer engagement with the Review and the Medical Services Advisory Committee process

All healthcare consumers should be provided with the opportunity to participate or be represented throughout MBS review and the ongoing MSAC processes. In particular, groups of consumers such as those from rural and regional areas, indigenous consumers and those from culturally and linguistically diverse backgrounds, consumers with a disability and other minority groups need be targeted specifically and encouraged to participate in MBS processes and the health system generally.

Defining the consumer

Currently anyone who is not a medical practitioner is considered a consumer. CHF has anecdotal evidence of legal practitioner being appointed as 'consumer

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[6] See http://www.abc.net.au/news/2015-09-28/duckett-removing-tests-from-medicare-wont-solve-over-treatment/6810318 viewed October 22 2015.

representatives' to Clinical Committees. This does not accord with the view that CHF has of the healthcare consumer. Indeed, taking such a broad view – that anyone not a medical practitioner can be considered as representing healthcare consumers – is to rob the role of its inherent value. Healthcare consumers form an important part of a system of individuals/organisations that provide feedback to medical practitioners, administrators and policy makers. The system is made up of the following individuals/organisations:

- Healthcare consumer – person with an experience of the health system;
- Patient advocate – A person who has the training to support a person to navigate the health system;
- Consumer representative – A person who is trained and supported to advocate for consumer-centered healthcare on committees, boards etc; and
- Healthcare consumer organization – An independent organisation of consumers, carers and/or people interested in working to improve consumer centered care; and
- Consumers Health Forum of Australia – The independent national peak body representing the interests of Australian healthcare consumers and its members.

The healthcare consumer forms the top of this hierarchy of organisations. A healthcare consumer is defined as a person with an experience of the health system. Such a definition implies that the healthcare consumer is person with more than a 'one off' interaction with the health system. They are experienced in that they have had many interactions with the health system and, although not always the chronically ill are more likely to be so and have such a close relationship with the health system that they dedicate their time in order to give medical practitioners, administrators and policy makers the benefit of their experience.

Consumer input is valuable and should be valued

In looking at how to improve patient and broader consumer involvement in the process CHF suggests that the values developed by the Health Technology Assessment International (HTAi) special interest group that looks at patient and citizen involvement in the health technology assessment (HTA) process are a useful starting point.

Values for Patient Involvement in HTA [7]

- **Relevance**

  Patients have knowledge, perspectives and experiences that are unique and contribute to essential evidence for HTA.
- **Fairness**

  Patients have the same rights to contribute to the HTA process as other stakeholders and have access to processes that enable effective engagement.

[7] HTAi Values and Standards viewed at http://www.htai.org/interest-groups/patient-and-citizen-involvement/pcig-home/values-and-standards.htm on l8/9/2015

- **Equity**

  Patient involvement in HTA contributes to equity by seeking to understand the diverse needs of patients with a particular health issue, balanced against the requirements of a health system that seeks to distribute resources fairly among all users.
- **Legitimacy**

  Patient involvement facilitates those affected by the HTA recommendations/decision to participate in the HTA; contributing to the transparency, accountability and credibility of the decision-making process.
- **Capacity building**

  Patient involvement processes address barriers to involving patients in HTA and build capacity for patients and HTA organisations to work together.

There are two levels of consumer engagement in this process, at the general HTA level and for individual assessments. It also needs to make a distinction between the involvement of the broader community as consumers or in HTAi terms citizens who have an interest in seeing the system deliver optimal outcomes to benefit everyone and the involvement of patients in individual assessments who have a vested interest in the particular medicines assessed.

There needs to be a more systematic and clearly articulated to consumer engagement strategy for the MBS review and to the ongoing MSAC processes.

The Review has included consumer representatives on the clinical committees which will be overseeing the reviews of group of items but this has been an ad hoc process with no clear guidance on criteria for selecting consumers and no clear statement on the role of those consumers in the committees. CHF is working with the Taskforce to examine these issues in more detail at a workshop with the aim of developing an engagement strategy that will be used for the rest of the reviews in 2016 and feed into MSAC processes in the future.

MBS Rules

The rules which attract the most comment from consumers are around referrals to specialist with concerns raised about cost, timing and choice for consumers. There is a lack of clear information about the referral process with many consumers relying on their GPs and/or specialists to manage the process for them.

Indefinite referrals

Annual renewal of referrals is a complete waste of time and resources for healthcare consumers and doctors. This is particularly so for someone with a chronic illness or a condition which has been treated and he or she is going back for periodic review. The Human Services website specifically points to the option for indefinite referral as follows:

> If a patient's condition requires continuing care and management by a specialist or consultant physician, GPs can write a referral for longer than 12 months. GPs may also use their clinical judgement to decide that an

> indefinite referral to the specialist or consultant physician would be appropriate.[8]

This option for indefinite referral is not well utilised/not well known by healthcare consumers and GPs. Certainly some specialists do not want indefinite referrals as they are gaming the system – treating a renewal of a referral as a trigger for an initial assessment which carries a higher fee and higher MBS rebate:

> Accepting only 'new' referrals technically allows specialists to charge for an initial consultation, which attracts a rebate $36 above the MBS item for a typical specialist consultation.[9]

The CHF believe that rules around referrals should be clearer and indefinite referral should be the default. Unlike pathology or diagnostic referrals referral to specialists are not transferable – they are usually from a GP to a particular doctor. If the patient can't get in to see that doctor, thinks the fees are too high or has a preference to go to someone else they have to return to the GP and get another referral. This is a waste of GP time and is a waste of money for MBS and for patients in terms of out of pocket expenses.

Referral to named specialist

Consumers have raised the issue of why specialist referrals cannot be similar to those for diagnostic tests or pathology, which are transferable providers.

It is accepted medical practice for referrals to address a specialist by name where possible despite the fact that *Health Insurance Act 1973* and *Health Insurance Regulations 1975* do not require that the referring practitioner address the other practitioner by name. Providing that all the other legal requirements have been satisfied and the referral is taken up by one specialist only, the referral is valid.

It is not well understood by consumers that even when a specialist is named on the referral, they do not have to see that specialist for the initial attendance; they can in fact shop around and find another specialist who may have a shorter waiting time, lower costs or be preferred for some other reason. However, once a referral has been used by a specialist for an initial attendance, it cannot be used again by a different practitioner for a subsequent attendance. Only where a new referral is obtained can a different practitioner claim the relevant referred consultation items.

Time of effect for referrals

The Human Services website specifically points out that the period for a referral is from the date the patient is first seen:

> Unless otherwise specified, referrals from a general practitioner (GP) to a specialist have duration of 12 months. This period begins from the date that

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[8] See http://www.humanservices.gov.au/health-professionals/subjects/referrals-under-medicare viewed 28 October 2015.

[9] See http://www.australiandoctor.com.au/news/latest-news/battle-with-specialists-over-indefinite-referrals?t=635816507042755467 viewed 28 October 2015.

the specialist first attends the patient, not from the date the referral is issued by the GP.[10]

Section 31 1(c) of the *Health Insurance Regulations 1975* states as follows:

> 31 Period of validity for referrals
> (1) Unless the period of validity for a referral is otherwise provided for in this regulation, the referral may state a period for which it remains valid and it will remain valid:
> (c) if the referral does not provide for its validity — for 12 months **after the first service** given in accordance with the referral.[11]

In talking with healthcare consumers this does not seem well understood and it is a cause of anxiety for many, even those who have had a number of such referrals. It should be more widely disseminated to GP's and specialists that a referral is valid 12 months 'from the date that the specialist first attends the patient, not from the date the referral is issued by the GP.' Of course, if annual reviews were used much less and, by implication, indefinite referrals used much more this would not be a problem.

Conclusion

This initial consultation process has given all stakeholders the opportunity to look at the process and identify key areas for review.

CHF thinks there would be merit in making the MBS more accessible to consumers, by having some accessible fact sheets on key issues and ensuring there is a plain English available so people can check issues out for themselves and have more understanding how the system works .

CHF sees the referral rules as an area for reform that would decrease wastage and improve health outcomes by moving to making indefinite referral the default position and making referrals more transferable. Given the degree of confusion over the rules around referrals CHF believes that there would be benefit in having some fact sheets about referrals, written in plain English which could be broadly disseminated so people have a better understanding of the process and what control they can have over the referral process.

CHF is looking forward to seeing the outcomes of the reviews from the first groups being considered as this will highlight how the review process is operating and will give some indications of potential problems in identifying the need for items to be amended and how those changes will be implemented.

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[10] See http://www.humanservices.gov.au/health-professionals/subjects/referrals-under-medicare viewed 28 October 2015.

[11] See https://ama.com.au/article/medicare-requirements-referrals-specialists-and-consultant-physicians viewed 28 October 2015 (emphasis added.)

There needs to be a more systematic and transparent process of consumer engagement in the review process. CHF looks forward to working with the Review Taskforce to develop such a strategy and assist in its implementation.