Submission to the

Medicare Benefits Schedule Review Taskforce Consultation

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Contact:

Alison Verhoeven
Chief Executive
Australian Healthcare & Hospitals Association
T: 02 6162 0780 | F: 02 6162 0779 | M: 0403 282 501
Post: PO Box 78, Deakin West, ACT 2600
Location: Unit 8, 2 Phipps Close, Deakin, ACT
E: averhoeven@ahha.com.au
W: www.ahha.asn.au

Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission to the Medicare Benefits Schedule (MBS) Review Taskforce as part of its consultation process.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, and individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

Much of the recent focus for health policy discourse in Australia has been on economics and funding, and the importance of building sustainability into the Australian healthcare system. The economics of healthcare and a healthy population contributing to the economy underpinned the establishment of Medicare more than 30 years ago, and it is timely that the Australian community should refocus on ensuring Medicare retains its capacity to support accessible universal healthcare for all Australians into the future. The Commonwealth Government's *Healthier Medicare* initiative, or which the MBS Review Taskforce is a component, is a positive step forward.

Medicare was founded on the principles of universality of access regardless of a person's financial circumstances, and it was developed to support a fee-for-service structure for a comprehensive range of services, providing health benefits and value for money, and that service provision and pricing should support high-quality service provision.

The MBS is a key component of the Medicare system as it lists out-of-hospital services provided by private practitioners as well as private patients in-hospital services. There are now more than 5,700 MBS items of which the majority are longstanding. Only a small portion of MBS items have undergone the Medical Services Advisory Committee's (MSAC) evidence-based assessment that new services undergo before they can be added to the MBS. There is a clear need for a review of MBS items to ensure they are evidence-based, fit-for-purpose, reflect contemporary medical practice and offer value for money.

MBS Review Taskforce vision and process

Previously, the AHHA supported the work of the Comprehensive Management Framework for the MBS, and the AHHA now supports the newly established MBS Review Taskforce and its work of undertaking future MBS reviews.

The AHHA supports the Taskforce's vision of reforming the MBS over the short-, medium- and long-term to provide affordable universal access to best-practice health services that represent value for the individual patient and the health system.

In the Elshaug et al. 2012 article examining potentially low-value health care practices in Australia, the authors note that, internationally, a common public concern with disinvesting health care practices is the perception of fairness and transparency in identifying and prioritising suboptimal health care practices for consideration and disinvestment[1]. To counter this issue, the Taskforce must ensure that its short-, medium- and long-term practices and processes:

[1] Elshaug, A, Watt, AM, Mundy, L & Willis, CD 2012 'Over 150 potentially low-value health care practices: an Australian study', Medical Journal of Australia, 197 (10) pp. 556-60.

- are evidence-based with robust mechanisms to consider the effectiveness and ongoing relevance of MBS items over the long-term, which involves identifying outdated items and replacing them with new items that conform with current medical practices
- embrace due diligence whereby the multiple review processes across the health sector do not result in fragmented and uncoordinated responses, poor communications and poorer decision-making
- allow for new, revised and de-listed items as core to its work
- link potential savings realised through de-listed items to newly recommended items
- support improved integration across multidisciplinary teams across both community and hospital based health services
- are based on patient centred and holistic care
- bring together clinicians, consumers, researchers and service representatives with comprehensive and regular stakeholders consultations that fully engages frontline clinicians and the communities they serve
- consider the implications and impacts of the Taskforce's recommendations across the whole health system and that the Commonwealth seeks to implement these recommendations in an evaluated, structured and considered approach
- balance the community's expectation of what it wants from its health care system
- encourage high value choices for consumers and their treating health service providers supported by evidence and best-practice in line with individual clinical and social circumstances
- support preventative care, quality of life and longevity as well as focus on the value or health benefit gained from individual treatments
- consider unintended consequences of implementation of any changes and work to prevent perverse incentives that risk unintended negative workforce and patient care outcomes

MBS Review Taskforce's focus and breadth

The Taskforce should focus more broadly than the immediate driver of cost containment. While it is important that the cost-benefit of existing MBS items is critically assessed, there must be provisions made for procedures and tests currently not on the MBS to be added where they would add value to the Australian taxpayer.

Reinvesting savings

The AHHA maintains that concerns over the level of health expenditure must not be viewed in the context of cyclical variations in the economy. Just as the Governments ask the Australian public to accept their fiscal strategy over the long term, so too must the Australian health system be funded with a view to the long-term benefits of a well-functioning and funded healthcare system.

The work of the Taskforce should not be viewed through the prism of budgetary cycles and a drive for budgetary saving but as an opportunity to guarantee a 21st century and modern health system based on best medical procedures and practices. Framing the Taskforce's work as an exercise to identify and achieve savings is counter-productive and will potentially undermine the goodwill the health sector brings to the process. New, revised and de-listed items should be core to the review, and any potential savings from de-listed, inefficient services should be earmarked for reinvestment in cost effective and best-practice medical services.

A modern MBS

The MBS as a mechanism of funding universal access healthcare must continue to respond to the changing demands of the Australian public. Chronic disease accounted for 90 per cent of all Australian

deaths in 2011 and its prevalence continues to rise[2]. The capacity of the MBS to support health professionals to respond to the needs of those with chronic disease must be assessed and where appropriate, altered accordingly. This may take the form of bundled payments, and the introduction of mechanisms to take into account outcomes measurement. Ensuring clinicians are appropriately incentivised to both treat and consult with consumers, and to interact with other elements of the primary and acute sectors, should be a primary focus of a 21st century MBS.

Medical Services Advisory Committee reviews

Established in 1998, the Medical Services Advisory Committee (MSAC), uses an evidence-based approach to advise the Commonwealth Minister for Health on evidence relating to the safety, effectiveness, and cost-effectiveness of new medical technologies and procedures. While the AHHA acknowledges the work that MSAC has completed to date, we also note that:

- the vast majority of the items on the MBS schedule have not been formally assessed against contemporary evidence of safety, effectiveness and cost-effectiveness
- this program needs be re-orientated and streamlined to make more speedy determinations on higher cost MBS items where there is an existing level of awareness of the lack of effectiveness of the treatment
- the Taskforce is also able to recommend new MBS items

Choosing Wisely in Australia

The Taskforce should take into consideration the work being done separately by the clinician-led Choosing Wisely program, led by the Government-funded organisation, NPS MedicineWise.

The AHHA supports initiatives like Choosing Wisely, a program driven by clinicians who use an evidence-based approach to identify low-value or no-value investigations and treatments to free up resources for the provision of more effective and timely care for those who will benefit most.

Linking the MBS review process to the Choosing Wisely program would create efficiencies through the common evidentiary review processes, as well as through the disinvestment decisions that would be mutually agreed across Government and clinicians

The Choosing Wisely campaign was launched in the US in 2012 to encourage physicians and consumers to work together in making better health care choices. The US has estimated the top 5 overused clinical activities in just three primary care specialities (paediatrics, internal medicine and family medicine) cost the health sector well in excess of $US5 billion[3]. In Australia this program holds potential to lower expenses through the MBS and offer considerable savings to the health system. The Choosing Wisely campaign will encourage a much needed 'fundamental shift of medical practice to maximising high-value care'[4]. The AHHA notes that the Department of Health has also identified the potential of a Choosing Wisely approach to minimise no- and low-value interventions[5] and that the Productivity Commission has also favourably cited this approach to improving productivity within the health sector[6]. Key components of this program are:

- medical colleges and professional associations lead the identification of low-value or no-value investigations and treatments to free up resources for the provision of more effective and timely care for those who will benefit most

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2 Australian Institute of Health and Welfare 2014, 'Leading types of ill health. 4.2 Chronic disease—Australia's biggest health challenge', Australia's health 2014.

3 Minal KS, Bishop T, Federman A & Keyhani S: "Top 5" Lists Top $5 Billion, JAMA Internal Medicine 2011 Vol 171, No. 20.

4 Scott, I: Ten clinician-driven strategies for maximising value of Australian health care, Australian Health Review 2014, 38.

5 Department of Health FOI Request 100-1415, Document 8 (accessed 5 February 2015).

6 Productivity Commission 2013, An Ageing Australia: Preparing for the Future, Commission Research Paper, Canberra.

- the program encourages clinicians to identify care options that are based on comparative cost-effectiveness, which would better support health professionals to make a care choice based on the 'less is more' principle, maintaining delivery of high quality care but in a cost-effective way
- patients benefit by avoiding unnecessary tests and interventions with the associated costs, inconvenience, loss of time and productivity (note that this work has already commenced in Australia, led by NPS Medicine Wise in collaboration with professional colleges and others)

MBS legislation and rules

The *Health Insurance Act 1973* sets out the broad principles and definitions governing the MBS, and it also sets out eligibility criteria for health care providers seeking to provide Medicare-eligible services, and prohibits the payment of benefits in certain circumstances such as for services that are wholly or partially funded from another government source. Other key pieces of legislation include the *National Health Act 1953* and the *Private Health Insurance Act 2007*. A number of regulations also affect and govern the MBS: the *Health Insurance Regulations 1975*, the *Health Insurance (General Medical Services Table) Regulations 2015*, the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2015* and the *Health Insurance (Pathology Services Table) Regulations 2015*.

The AHHA submits the following case study from North and West Remote Health (NWRH) in Queensland as an examples of how the current MBS legislation and rules can negatively affect access to health services. The AHHA supports a thorough review of existing MBS related rules and regulations to enhance the delivery of patient-centred, quality care.

North and West Remote Health

NWRH has sought to gain access to the MBS through its Normanton Medical clinic for a number of years and has been unsuccessful due to its ineligibility under Commonwealth requirements. NWRH is a not for profit primary health care organisation providing a wide range of allied and Primary Health services across Regional Townsville, the North West, Central West and Lower Gulf regions of Queensland since 2001.

During 2010 the former association North and West Queensland Primary Health Care, now NWRH, commenced receiving MBS rebates for activities conducted within its Medical clinic located in the Lower Gulf (Normanton). During 2011 it was discovered that the association was claiming in error and was required to repay approximately $250,000 to the Commonwealth as it did not fit the requirements to claim MBS items. The reason for this was that the association was not an Aboriginal Medical Service (AMS) and was a Commonwealth funded organisation. Both of these reasons still hold today in preventing NWRH from claiming MBS items through its medical clinic. The Medical clinic is accredited by Australian General Practice Accreditation Limited and staffed with a team of general practitioners, nurses, midwives and Aboriginal health workers.

The more than 1,000 active Aboriginal and Torres Strait Islander clients accessing NWRH's Normanton Clinic for primary health needs cannot access Closing the Gap pharmaceutical medications because NWRH, as their primary health provider, cannot bulk bill through the MBS. Consequently, poor health outcomes associated with chronic disease management are being seen due to non-compliance with clients purchasing medications.

NWRH notes the following list of issues negatively impacting on its clients' health outcomes and access more broadly:

- NWRH is unable to provide access to services associated with Team Care Arrangements (MBS Item 721). As NWRH is unable to bill MBS Item 721, referred service providers cannot provide Team Care Arrangement services to patients free of charge. This impacts access to allied and mental health services.

- Carers of Dementia sufferers are not eligible for subsidised care through the MBS system which poorly influences delivery of evidence-based dementia services.
- NWRH's data is not reflected in the MBS data, which is used by the Commonwealth to inform policy decisions. Data extraction from systems such as OCHREStreams which links directly to MBS Item Numbers is consequently a time-consuming process for government departments.
- Immunisation data cannot be downloaded directly to Public Health Units through the electronic billing system of medical software. This is a risk to clients who do not have up-to-date immunisation histories on the Queensland Register due to the delays associated with hard-copy transfer of information. Consequently, an increase in wrong administration of vaccines has been identified.
- Telehealth services that are crucial to timely access to specialist health care in rural and remote areas are unable to be subsidised through the MBS system which decreases access.

MBS data

The Medicare system generates large volumes of data about benefits paid for health services delivered to Australians. In parallel, the health system more broadly gathers information about consumer health outcomes. However, Australia does not have robust data or data linkage to drive outcomes. In the first instance, the AHHA calls on the Commonwealth to go beyond collecting MBS data simply against item numbers but to begin collecting and making publicly available MBS data against de-identified individuals and families, which would significantly improve the sector's understanding of demand and usage.

MBS and public hospital interface

Australians have the right to choose to be treated as a public patient in a public hospital free of charge. Private patients in public or private hospitals will be charged for their accommodation and treatment and are able to access MBS benefits and private health insurance to assist in meeting these costs. MBS benefits are not, however, available for public patient services.

While the payment of Medicare benefits for services provided under an 'arrangement' with the Commonwealth, the States and Territories, and a range of other bodies are prohibited, it has long been the case that salaried medical practitioners working in public hospitals can also see their own patients under rights of private practice, and it is permissible to claim Medicare benefits for these services. The evolution of these practices and the lack of transparency across the system mean that different benefits flow to different patients for the same service, depending on local practice.

The AHHA advocates for flexibility of practice to meet the needs of consumers in their local setting while at the same time calling for greater transparency to maintain and enhance the integrity of the MBS as well as ensuring it is not gamed or abused to the detriment of the broader community.

Rationalisation of unnecessary GP visits

There are opportunities to achieve MBS savings through reduction of unnecessary GP presentations, for example through encouraging employers to require medical certificates for sick leave only where there is prolonged use of leave, reducing the requirement for GP referrals to specialists in circumstances such as repeat annual visits and continued case management, and where a referral could be made for defined conditions by allied health professionals such as physiotherapists. Similarly, it should not always be necessary to see a GP where the patient only needs to have a prescription renewed for an ongoing and well-maintained condition.

The scope of practice and expertise of allied health professionals should be reflected in the MBS. Where specific services can be provided effectively and safely by other health professionals (e.g. as determined by the National Board regulating that profession), the MBS item should not be what

restricts them being able to provide that service. The use of less expensive health professionals working to the extent of their scope of practice, substituting for high cost health professionals, would enhance the efficiency of the health care system,[7] for example physiotherapists referring a patient directly to a specialist in defined circumstances in place of requiring them to first consult a GP.

End of life planning

Australia needs to formally imbed planning for end of life care needs and intentions into both health and aged care practices. For example, each resident assessed for entering a residential aged care facility should have a care plan prepared as part of their entry requirements. Regardless of an individual's age or health status, this care plan should then be reviewed on a regular basis to reflect the changing needs and wishes of the resident. Better end of life planning has the potential to improve patient outcomes while also providing savings to the health system. With an ageing population, this proposal is a sensible approach towards the dignified treatment of elderly Australians and for the health and aged care systems.

An MBS item could be established that supports the central involvement of GPs in end of life planning. This plan could be linked into a patient's eHealth record which would support care being provided that aligns to the wishes and needs of the patient, regardless of what part of the health system they access. Such an MBS item could form part of a set of linked items on chronic disease management and integrated care.

Oral health

Oral conditions are the second most expensive disease group to treat in Australia. Unlike other health services, the cost of oral health largely falls on the individual. In 2011-2012 individuals were responsible for 57 per cent of the total cost of dental care compared to only 12 per cent of the cost of all other health services.[8]

The AHHA supports oral health being considered as a part of overall health as well as being considered as part of the Taskforce's review.

Good oral health is fundamental to health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment.

Oral health problems impact on general health. As well as common risk factors with chronic diseases, oral disease is significantly associated with major chronic diseases including cardiovascular disease, diabetes, stroke and respiratory disease. Poor oral health can also impact on birth outcomes, including preterm-births and low birth weight.

The inclusion of item numbers relating to oral health assessment and referral in the MBS has the potential to lead to significant improvement in oral health and, in turn overall health, particularly for the most vulnerable Australians.

Mental Health

Mental health plans and access to clinical pathways and resources, enabled through a mental health plan, are examples of what the AHHA considers high value patient care funded through MBS. GPs and other health professionals alike have the opportunity to undergo additional skills training, enabling

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[7] Leggat S. Changing health professionals' scope of practice: how do we continue to make progress? Deeble Institute Issues Brief. Canberra: Australian Healthcare and Hospitals Association; 2014.

[8] Australian Institute of Health and Welfare 2012, Australia's health 2012 Australia's health no. 13. Cat. no. AUS 156. Canberra.

access to higher MBS rebates and improved healthcare resources, for example referral to psychologists often at more affordable rates or no cost.

eHealth

The AHHA acknowledges the Commonwealth Government's continued support for the national implementation of eHealth tools and resources as holding immense potential to support high quality and consistent care, as well as supporting a number of efficiencies and reduction of waste.

The benefit and value of the use of standardised use of electronic health records are well documented: better information sharing and communication between healthcare providers and between patient and provider; reduced duplication or over-servicing; more efficient and more appropriate treatment; and responds to needs of both clinicians and consumers by being portable and transferrable. Electronic health resources also stand to better support prescribing and referrals for tests and other procedures and would align with other efforts to reduce inappropriate or unnecessary testing and medication prescription.

Greater use and entrenchment of personal electronic health records would:

- further integrate and support appropriate care regardless of the point of access in the system
- provide a greater focus on a digital healthcare system would also support better performance reporting
- enhance the capability to allow for performance reporting in real time and across the community through linked data collected and analysed to support quality service provision, achievement of health outcomes and responsiveness in delivery of programs and services that meet identified needs
- allow for information sharing across health services, both public and private, enabling governments and other funders to identify better utilisation of resources for health

The AHHA calls on the Taskforce to consider how to increase the effective use of eHealth processes, including My Health Record.

Prevention

In her 28 October 2015 address to the National Press Club, Commonwealth Minister for Health Sussan Ley underscored the value of better preventive health and early intervention measures. While investing in preventive health measures generates a short term cost, it will also create savings in reduced health care costs down the track. With the Commonwealth, State and Territory governments currently facing budgetary pressure from rising health costs, it is vital that preventive health strategies be encouraged to lessen the individual, intergenerational and health system burden which will otherwise emerge in the future.

Expenditure on preventative health measures can legitimately be viewed as contributing to fiscal repair by reducing future demand on the health system while simultaneously improving health outcomes for all Australians.

Through participation in the WHO, Australia has committed to reducing premature mortality from the four major non-communicable diseases by 2025. These include cardiovascular disease, cancer, chronic lung diseases and diabetes.

Hospital services accounts for around 40 per cent of health expenditure in Australia. Investment in effective prevention efforts and primary health care programs aimed at addressing these four disease groups will support reduction in hospitalisations, leading to lower hospital expenditure.

The direction of health policy today will have a tangible impact on the problems faced by the health system in the future. The Taskforce should consider how the MBS can help guide investing in preventive health measures as a low cost way of reducing future fiscal pressure while also improving the wellbeing of all Australians.

Bundled payments and other funding options

The current MBS is an uncapped, demand-driven fee-for-service program. In her 28 October 2015 address to the National Press Club, Commonwealth Minister for Health Sussan Ley stated Medicare's fee-for-service model works for episodic and acute care but less so for chronic disease.

The challenge of increasing chronic disease, multi-comorbidities and how the health system can more effectively respond to these pressures must also be considered by the Taskforce in the quest for a more efficient health that better meets consumers' needs. If care was better integrated between primary, acute and aged care, there would be a significant incentive to avoid costly hospital admissions through more effective primary care and community based management of an individual's health care needs.

The challenge with the MBS's fee-for-service model is that it promotes an emphasis on activity rather than outcome, and episodic rather than coordinated, multidisciplinary care. The Taskforce should investigate and recommend alternative funding models such as bundled payments for identified chronic conditions that could be introduced in order to support optimum care based on the current disease burden. Reforming payment models in relation to the care and support needed in the community should form part of a modern and responsive health system. This was a key finding at the AHHA's September 2015 think tank on health funding[9] as well as AHHA's *Pathways to Reform* paper, 'Bundled payments: their role in Australian primary health care'[10].

Conclusion

The MBS Review Taskforce has a complex and important task ahead, and the AHHA welcomes the opportunity to support its work. Leadership in the field of health needs to represent more than just financial cuts and cost saving measures. The AHHA commends the options and considerations outlined in this submission to the Taskforce and hopes it will take them into account as Australia strives toward building a modern, 21st century health system based on current medical procedures and practices that places the consumer at the centre rather than the payment system at the centre.

[9] See presentations and communique from AHHA's 15 September 2015 Think Tank on Sustainable Funding of Public Hospitals: https://ahha.asn.au/think-tank-sustainable-funding-public-hospitals-0

[10] See 'Bundled payments: their role in Australian primary health care' and other *Pathways to Reform* series research papers: https://ahha.asn.au/Federation-and-Health