A Look Downunder: How Australia Reviewed Its Entire Medicare Fee-for-Service Schedule Focusing on Quality and Value

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• Private Healthcare Australia
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• ACSQHC: Atlas of Health Care Variation Advisory Group;
• Cancer Australia: ‘Statements’ Advisory Committee;
• Cancer Australia: Health Economics and Policy Advisor;
• Cancer Council Australia: Health Services Advisory Committee;
• Expert Advisory Committee for Evidence-based Interventions
  (Academy of Medical Royal Colleges, NHS Clinical Commissioners (NHSCC), the National
  Institute for Health and Care Excellence (NICE), NHS England and Improvement)
• (Immediate Past): Choosing Wisely (Australia) Advisory Group (NPS)
Australia: expenditure on health

- Population: 26 million (between Texas and Florida)
- In 2016-17, total health spending in Australia was estimated at AUD$181 billion (USD 135 Billion)
- Equated to 10.3% of Gross Domestic Product (GDP)
- Majority of funding is from government:
  - 67% from Commonwealth and states /territories (72% OECD ave)
- Remainder of funding is by non government sector:
  - 17% via patient out-of-pocket expenses
  - Balance by private health insurers and through accident compensation schemes

California (39,747,267); Texas (29,087,070); Florida (21,646,155); New York (19,491,339)

Source: Australia’s Health 2016
Exhibit 1

Health Care Spending as a Percentage of GDP, 1980–2014

GDP refers to gross domestic product. Data in legend are for 2014.

Source: OECD Health Data 2016. Data are for current spending only, and exclude spending on capital formation of health care providers.
Life expectancy vs. health expenditure over time (1970-2014)

Health spending measures the consumption of health care goods and services, including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments. Shown is total health expenditure (financed by public and private sources).

Data source: Health expenditure from the OECD; Life expectancy from the World Bank. Licensed under CC-BY-SA by the author Max Roser. The interactive data visualization is available at OurWorldinData.org. There you find the raw data and more visualizations on this topic.
### Health Care System Performance Rankings

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Source: Commonwealth Fund analysis.
Exhibit 3

Health Care System Performance Scores

Higher performing

Lower performing

Note: See How This Study Was Conducted for a description of how the performance scores are calculated.

Source: Commonwealth Fund analysis.
Exhibit 4

Mortality Amenable to Health Care, 2004 and 2014


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<td>Smoking, % of population aged ≥15 y who smoke daily</td>
<td>France 22.4</td>
<td>Germany 20.9</td>
<td>CHE 20.4</td>
<td>NLD 19</td>
<td>Japan 18.2</td>
<td>Denmark 17</td>
<td>UK 16.1</td>
<td>Canada 14</td>
<td>Australia 12.4</td>
<td>US 11.4</td>
<td>Sweden 11.2</td>
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<td>Alcohol consumption, L per capita in population aged ≥15 y</td>
<td>France 11.8</td>
<td>Germany 11</td>
<td>Australia 9.7</td>
<td>UK 9.5</td>
<td>CHE 9.5</td>
<td>Denmark 9.4</td>
<td>US 8.8</td>
<td>Canada 8.1</td>
<td>NLD 8</td>
<td>Sweden 7.2</td>
<td>Japan 7.2</td>
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<td>Obese or overweight, % of population aged ≥15 y</td>
<td>US 70.1</td>
<td>Australia 63.4</td>
<td>UK 62.9</td>
<td>Canada 60.3</td>
<td>Germany 60</td>
<td>France 49</td>
<td>Sweden 48.3</td>
<td>Denmark 47.4</td>
<td>CHE 41</td>
<td>Japan 23.8</td>
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| Life expectancy         |   |   |   |   |   |   |   |   |   |    |    |      |
| Life expectancy in total population at birth, mean, y | Japan 83.9 | CHE 83 | Australia 82.5 | France 82.4 | Sweden 82.3 | Canada 81.7 | NLD 81.6 | UK 81 | Sweden 80.8 | Germany 80.7 | US 78.8 | 81.7 |
| Health-adjusted life expectancy, mean, y | Japan 74.9 | CHE 73.1 | France 72.6 | Canada 72.3 | NLD 72.2 | Sweden 72 | UK 71.4 | Australia 71.9 | Denmark 71.3 | 71.2 | US 69.1 | 72 |
| Life expectancy for women aged ≥40 y, mean, y | Japan 47.7 | France 46.4 | CHE 45.8 | Australia 45.4 | Sweden 44.8 | Germany 43.9 | NLD 43.9 | UK 43.7 | Denmark 43.4 | US 42.6 | 44.8 |
| Life expectancy for men aged ≥40 y, mean, y | CHE 42 | Japan 41.8 | Australia 41.7 | Sweden 41.5 | Germany 41.1 | NLD 40.8 | France 40.6 | UK 40.5 | Denmark 39.8 | 39.4 | US 38.7 | 40.7 |

| Maternal and infant health |   |   |   |   |   |   |   |   |   |    |    |      |
| Maternal mortality, deaths per 100,000 live births | US 26.4 | UK 9.2 | Germany 9 | Japan 7.8 | Canada 7.3 | NLD 6.7 | Japan 6.4 | CHE 5.8 | Australia 5.5 | Sweden 4.4 | Denmark 4.2 | 8.4 |
| Infant mortality, deaths per 1000 live births | US 5.8 | Canada 5.1 | UK 4.9 | CHE 3.9 | France 3.8 | Denmark 3.7 | Germany 3.3 | NLD 2.5 | Sweden 2.5 | Australia 2.1 | Japan 2.1 | 3.6 |
| Neonatal mortality, deaths per 1000 live births | US 4 | Canada 3.2 | UK 3.1 | CHE 2 | Denmark 3 | UK 2.7 | France 2.6 | NLD 2.5 | Sweden 2.5 | Australia 2 | Japan 0.9 | 2.6 |
| Neonatal mortality, deaths per 1000 live births excluding <1000 g | Denmark 2.09 | NLD 1.96 | UK 1.77 | CHE 1.63 | US 1.61 | Sweden 1.56 | France NA | CHE NA | Japan NA | Australia NA | 1.7 |
| Low birth weight, % of total live births | Japan 6.5 | US 8.1 | UK 6.9 | Germany 6.6 | NLD 6.5 | Australia 6.4 | Canada 6.3 | France 6.2 | Denmark 5 | Sweden 4.4 | CHE NA | 6.6 |
Papanicolas I., et. al. Health Care Spending in the United States and Other High-Income Countries

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<td>Overall physicians per 1000 population</td>
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<td>Germany 4.1</td>
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<td>Australia 3.5</td>
<td>France 3.1</td>
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<td>Canada 2.6</td>
<td>Japan 2.4</td>
<td>UK 2.1</td>
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<td>Primary care physicians, % of total</td>
<td>France 54</td>
<td>CHE 48</td>
<td>Canada 48</td>
<td>NLD 47</td>
<td>US 45</td>
<td>Germany 45</td>
<td>Australia 45</td>
<td>Australia 45</td>
<td>US 43</td>
<td>Japan 33</td>
<td>Canada 22</td>
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<td>Specialists, % of total</td>
<td>Denmark 78</td>
<td>Sweden 67</td>
<td>US 57</td>
<td>Japan 57</td>
<td>Japan 55</td>
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<td>France 9.4</td>
<td>UK 8.2</td>
<td>11.8</td>
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| **Equipment per 1 million population** |    |    |    |    |    |    |    |    |    |    |    |      |
| Magnetic resonance imaging units | Japan 51.7 | US 38.1 | Germany 30.5 | Australia 14.7 | NLD 12.9 | France 12.6 | Canada 8.9 | UK 7.2 | Sweden NA | CHE NA | Denmark NA | 22 |
| Computed tomography units | Japan 107.2 | Australia 56.1 | US 41 | Denmark 37.1 | CHE 36.1 | France 35.3 | Canada 16.6 | NLD 13.3 | Canada 12.7 | UK 9.5 | Sweden NA | 36.5 |
| Mammography machine units | US 43.3 | Japan 33 | CHE 28.3 | Australia 23 | UK 21 | Canada 17.3 | Denmark 14.2 | France 7.5 | Germany NA | Sweden NA | NLD NA | 23.5 |

| **Beds** |    |    |    |    |    |    |    |    |    |    |    |      |
| Hospital beds per 1000 population | Japan 13.2 | Germany 8.2 | France 6.1 | CHE 4.6 | Australia 3.8 | NLD 3.3 | US 2.8 | UK 2.7 | Denmark 2.7 | Canada 2.7 | Sweden 2.5 | 4.8 |
| Long-term beds per 1000 population aged ≥65 y | Sweden 70.6 | CHE 67.6 | NLD 65.5 | France 59 | Australia 54 | Canada 53.7 | Germany 53.1 | US 49.5 | Denmark 48.9 | Canada 48.7 | Sweden 25 | 54.2 |

| **Health spending** |    |    |    |    |    |    |    |    |    |    |    |      |
| Total spending on health, % of total national GDP | US 17.8 | CHE 12.4 | Sweden 11.9 | Germany 11.3 | France 11 | Japan 10.9 | Denmark 10.8 | NLD 10.5 | Canada 10.3 | UK 9.7 | Australia 9.6 | 11.5 |
| Public spending on health, % of total national GDP | Sweden 10 | NLD 9.5 | Denmark 9.2 | Germany 8.7 | France 8.7 | Japan 8.6 | US 8.3 | CHE 7.7 | UK 7.6 | Canada 7.4 | Australia 6.3 | 8.4 |
| Mean spending on health per capita, US $ | US 9403 | Sweden 6808 | CHE 6787 | Denmark 6463 | NLD 5202 | Germany 5182 | Canada 4641 | France 4357 | Canada 3727 | France 3661 | UK 3377 | 5419 |
The Medicare Benefits Schedule (MBS)

A key feature of ‘Medicare’

- Introduced in 1984
- Covers professional services delivered privately in-hospital and out-of-hospital by health professionals
- Funds ‘clinically relevant’ services
- Includes over 5,700 items
- Key driver of health service delivery
RESOURCING AUSTRALIAN HEALTH CARE
UNIVERSAL, YES. SINGLE PAYER, NO.
Medicare rebates were provided for:
- 394 million services in 2016-17 (1 year)
  - An average of 16 services per capita
- 257 million services in 2006-07
  - An average of 12 services per capita

Medicare expenditure was:
- $22 billion in 2016-17
  - An average of $888 per capita
- $11.7 billion in 2006-07
  - An average of $563 per capita
The MBS is big...

- **Non-refferred Attendances**: $9.8 Billion
  - Level C Consultation: $1.16 Billion
  - Level B Consultation: $3.37 Billion
  - Specialist Attendances: $2.3 Billion

- **Professional Attendances**: $9.8 Billion
  - Non-refferred Attendances: $7.2 Billion
  - Level C Consultation: $1.16 Billion
  - Level B Consultation: $3.37 Billion

- **Diagnostic Imaging**: $3.2 Billion
  - Ultrasound: $1.1 Billion
  - Nuclear Medicine Imaging: $0.26 Billion
  - Magnetic Resonance Imaging: $0.4 Billion
  - Other Imaging: $0.2 Billion
  - Other Diagnostic Procedures: $0.3 Billion

- **Therapeutic Procedures**: $3.44 Billion
  - Surgical Operations: $1.77 Billion
  - Radiotherapy: $0.37 Billion
  - Obstetrics: $0.2 Billion
  - Other Therapeutic Procedures: $0.7 Billion

- **Pathology Services**: $2.65 Billion
  - Hematology: $0.3 Billion
  - Microbiology: $0.44 Billion
  - Chemical: $1.01 Billion
  - Other: $0.6 Billion
  - Other Diagnostic Procedures: $0.3 Billion
  - Value Guide for Anaesthesia: $0.4 Billion

Total MBS Expenditure in 2015-16: $21.1 Billion
Why do we need a review?

- 70% of MBS items have never been reviewed in 30 years
- Ensure the MBS is contemporary and supports best practice
- Improve clinical value
- Improve the financial value
- Address overuse, misuse and underuse of services
- Identify services that are unnecessary, outdated or unsafe
- Provide recommendations to the Medical Services Advisory Committee (MSAC) on new items
**HTA continuum**

- **Pre-clinical/Clinical development**
- **Horizon scanning**
- **Regulation**
- **Reimbursement/Adoption**
- **Post market surveillance**

- **TGA**: Therapeutic Goods Administration
  - Multiple sub-structures

- **PBAC**: Pharmaceutical Benefits Advisory Committee
  - Economics Sub-Committee (PBAC ESC)
  - Drug Utilisation Sub-Committee (DUSC)

- **MSAC**: Medical Services Advisory Committee
  - PICO Advisory Sub-Committee (PASC)
  - Evaluation Sub-Committee (MSAC ESC)

- **MBSRTF**: Medicare Benefits Schedule Review Taskforce
  - Principles & Rules Sub-Committee; Clinical Committees; Working Groups

- **PLAC**: Prosthesis List Advisory Committee
Opinion

Physician, Regulate Yourself

If doctors won’t help fix the problems of health care, they shouldn’t be outraged when outsiders try to do it for them.

By Sandeep Jauhar
Dr. Jauhar is a cardiologist.

Sept. 11, 2019
Membership of the Medicare Benefits Schedule Review Taskforce

Membership of the taskforce includes doctors with expertise in general practice, surgery, pathology, radiology, public health and medical administration, who work across both the public and private health sectors, as well as consumer representation and academic expertise in health technology assessment.

The membership is:

- **Professor Bruce Robinson** - Chair
- **Dr Steve Hambleton** - Deputy Chair; representative of PHCAG
- **Dr Matthew Andrews** - Clinical member (Diagnostic imaging)
- **Professor Michael Besser** - Clinical member (Neurosurgery)
- **Dr Eleanor Chew** - Clinical member
- **Dr Michael Cooilin** - Clinical member (Private provider)
- **Professor Adam Elshaug** - Health economist
- **Dr Tammy Kington** - Clinical member (General Practice)
- **Professor Paul Glasziou** - Clinical member (General practice)
- **Professor Michael Gregg** - Clinical member (Surgery)
- **Dr Lee Ganner** - Clinical member (Medical administration)
- **Ms Rebecca James** - Consumer representative
- **Dr Matthew McConnel** - Clinical member (Public health)
- **Dr Rev Rowbotham** - Clinical member (Pathology)
- **Dr Joanna Sutherland** – Clinical member (Anaesthetics)
- **Professor Nick Talley** - Clinical member (Medicine)
The MBS Review Taskforce:

- Reviews MBS items taking account of safety, clinically unnecessary services and clinical guidelines
- Commissions evidence-based reviews
- Advises the Minister for Health about the MBS and health financing issues
- Advises on a structure for ongoing review of the MBS
- Advise on a Departmental program of work that aims to update the *Health Insurance Act* and regulations
- Engages with health consumers, medical professionals, peak bodies and other stakeholders
The MBS Principles and Rules Committee reports directly to the Taskforce and considers issues which apply across the MBS at the system level. These include:

1. review of the legislation and regulation underpinning the MBS;
2. updating administrative and process issues relating to the operation of the MBS; and
3. guiding clinician behaviours relevant to the responsible and ethical use of the MBS as a public funding mechanism.

The Committee also develops principles to guide the Review’s clinical committees in developing their recommendations and designing new MBS items, and deals with referrals from clinical committees seeking clarification or endorsement of specific matters or proposals.
MBS Review and clinical committee structure
3 types of item-level recommendations can be made (delete, change, keep), with multiple options for change

- **Delete**
  - Patient / eligibility conditions
  - Place in clinical pathway
  - Co-claiming restrictions
  - Scope of services included (split or consolidate / bundle items)
  - Service conditions (e.g. duration, dose, frequency, route, modality)

- **Change**
  - Care setting / location of service
  - Provider / referrer restrictions
  - Schedule fee

- **Keep**
Prioritisation matrix

Magnitude of usage
- Service volumes
- Benefit outlays

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Likelihood that the item needs revision
- Identified safety concern
- Geographic/temporal variation
- Delivery irregularity
- Suspected indication creep
- Other
Every MBS Item has a ‘descriptor’, describing the service and it’s appropriate use (and fee)

A lot of progress has been made in refining the indications for (appropriate) use!

Here are some examples....
Example of MBS Item descriptors

‘Less restricted’ example:
“Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen, 4-6 antibodies” [fee]

‘More restricted’ example:
“Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of, for a patient who:
– (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms;
– Or (b) satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode”
– [fee]
Example of MBS Item descriptors

‘Most restricted’ example:
“Breast, malignant tumour, targeted intraoperative radiotherapy, using an Intrabeam® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who:
 a) is 45 years of age or more; and
 b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and
 c) has an histologic Grade 1 or 2 tumour; and
 d) has an oestrogen-receptor positive tumour; and
 e) has a node negative malignancy; and
 f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and
 g) has no contra-indications to breast irradiation.”
[fee]
Example of refining the indications:
25-Hydroxy Vitamin D Tests

Source: Elshaug analysis for Senate hearing.

Case study: colonoscopy items recommendations

Gastroenterology Clinical Committee found that colonoscopy is a low value service for many patients

Patients undergo unnecessary and too frequent testing

New MBS items ensure appropriate surveillance intervals of patients who are at increased risk of developing colorectal cancer

The Taskforce recommended changes to colonoscopy items to align with clinical practice guidelines
EXAMPLE: Co-Claiming
Case study: tonsillectomy items

• Ear, Nose & Throat Surgery Clinical Committee identified instances of inappropriate claiming of multiple items for a single service where these additional items are integral to the primary service

• The issue of co-claiming is most relevant to the surgical committees

Tonsillectomy
• 22% of surgeries claimed with items for examination of nasopharynx
• 12% of surgeries claimed with item for glossopharyngeal nerve block

The Taskforce recommended placing restrictions on co-claiming and item descriptors amended to clarify examination inclusions
Case study: multiple area spinal imaging

Allied health providers can request some MBS funded imaging (X-rays but not CTs or MRIs)

There are MBS items for single, two, three and four area spinal imaging

• 3 area imaging: ~125,000 services in 2013/14 with ~100,000 requested by chiropractors.
• 4 area imaging: ~15,000 services in 2013/14

The Taskforce recommended removing the ability by Chiropractors to request 3 & 4 region spinal x-rays, requesting be limited to medical practitioners.
SOME RESULTS SLIDES REMOVED DUE TO CONFIDENTIALITY
Process and timeframes

- A single review can take up to two years (and often longer) from establishment to implementation:
  - Clinical committee convenes
  - Taskforce endorsement of draft recommendations
  - Consultation
  - Committee/Taskforce consideration of feedback
  - Taskforce recommendations to Government
  - Government consideration and response
  - Regulatory changes
  - Implementation
Progress to date

100% MBS items reviewed or currently under review

70+ clinical committees and working groups established

>332 Recommendations made to Government (000’s of item numbers)

297 Recommendations accepted

>10,000 Submissions received from stakeholders

800+ Clinicians, consumers and health system experts involved
Next steps

• Main focus of the MBS Review is now transitioning from Review to Implementation.

• More than 800 changes per year are expected to the MBS Schedule each year until at least 2023 (this is from 50 per year, prior to the Review).

• It is critical to work with peak groups, clinicians and experts to ensure that changes deliver high-value care while ensuring no unintended consequences from a change.

• Implementation Liaison Groups, Forums and ongoing consultation is therefore vital.

• It is anticipated that the work of the Taskforce will be finalised by mid-late 2020
Ongoing ‘Rolling Review” Process
Cases that would trigger the review of an item

▪ Opportunities that were left unaddressed during the initial MBS review
▪ “Expiration date” for each item (or item group) by which it must be reviewed
▪ Monitoring of high-growth and/or -variability items for early detection of low-value care
▪ Introduction of items via MSAC may change how existing items should be appropriately claimed
▪ Changes in the evidence base affecting items or item groups
▪ Evaluation of the impact of implemented changes from the MBS Review, and course correction when required (E.g. actual versus expected utilization)
▪ Issues with items proactively raised by consumers or other stakeholders
▪ More cost-effectiveness analyses and; reviews of services within disease pathways rather than by specialty group
Thank you
elshaug@sydney.edu.au

Mueller Hut, Mount Cook Natl. Park, New Zealand