You are not Robinson Crusoe

A huge undertaking, but is it about improving outcomes or cutting costs?

Dean of Medicine at the University of Sydney, Bruce Robinson, is leading the Medicare Benefits Schedule (MBS) Review Taskforce in its examination of how more than 5500 listed services can be aligned with contemporary clinical evidence and improve health outcomes for patients.[1]

It would be informative if the federal government had the Department of Finance provide a figure indicating how much money it wants to save. Disguising a rationing exercise by saying it is about improving outcomes will cut little ice unless the level of rationing is acceptable to the medical profession.

Pricing MBS items is a cost-accounting exercise. Trying to evaluate whether a particular service, based on the Medicare price, improves health outcomes could lead the taskforce into a paper chase seeking clinical evidence, when the intent of the exercise is all about increasing cost efficiencies.

Advances in technology improve efficiency. Pathology services were an early target because the original MBS items were based on tests undertaken manually. Once tests became automated, throughput increased and pathology service providers made substantial windfall gains before the MBS prices were adjusted.

On the other hand, the pricing for cataract removal has been largely immune from any recognition of the advances in technology that have occurred since the first medical benefits table for each Australian state was established in the early 1970s.[2] When ophthalmologists protested strongly and publicly about a proposed cut in the fee for the Medicare benefit in 2010, the cut never eventuated; a compromise was reached in the government price.[3]

Determining fees for benefits

Trying to alter the relativities between the different medical tribes is thus a challenge. In determining the original MBS, advice was sought from the various groups on what were considered "fair and reasonable" fees. Because of the way they assessed their original fees, ophthalmologists have always been considered as being at the top of the relativity scale.

In the early years, the Australian Medical Association (AMA) and the federal government participated in regular enquiries into medical fees for medical benefits. This had the effect of reinforcing the acceptance of relativities between the services provided by different groups and specialties, because each submitted data to the AMA. As the AMA bore the cost of making the submission, it certainly was in its interests not to question the accepted relativities unless there were obvious shifts, as occurred with pathology services. The AMA was successful in having the prices for the services raised with every successive enquiry. The submissions were argued from an industrial perspective. There was no attempt to try to evaluate the effectiveness of individual procedures or consultations. With every enquiry, there was a sense within the AMA that the results were not as successful as the enquiry before. The last enquiry into medical fees for medical benefits was held in 1984.

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Since the end of those periodic enquiries, and with increasing specialisation, the AMA's role in the area of medical fees for medical benefits has diminished. The AMA releases a list of recommended fees annually, but the formula has not been updated. It is the MBS pricing that counts. Specialty groups sought recognition of the cost of advances in their fields in the Medicare benefits item descriptors. With no unifying force, it became a time when specialties strove for their own gain.

One example was in radiotherapy (radiation oncology). When the relativities were first determined, most radiotherapists, as they were then known, were salaried and their equipment was the most expensive item. There was little private radiotherapy. However, by the mid-1980s, there was considerable interest in providing a private service. In radiotherapy, it was crucial to recognise and differentiate the service price into three components: professional, technical and capital.

In terms of pricing, the professional component always dominated. The AMA had always asserted that all procedural pricing should embody the professional component of the price, taking into account office and car costs. Hospitals paid the cost of the technical staff and the imputed capital costs of using the facility. This resulted in cost shifting onto the state governments or private hospitals.

Radiation oncologists who saw a future in private practice knew that the price for the service was totally inadequate. There was no mechanism to handle the capital expenditure required, which depended on the international value of the Australian dollar. The technical component, comprising the staff and other non-capital costs, was measurable. The professional component was essentially a normative distillation of time to undertake the service (which is measurable) and the required level of skill and knowledge, often defined as complexity (a matter of opinion).

The end result, after long negotiation, was that radiation oncology in private practice was rendered viable. Based on detailed costing, the government separated the capital component of the Medicare benefit into a specific payment for major equipment that could be updated regularly to reflect actual costs.[4]

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At the same time, calculations to establish the new radiation oncology benefits also identified the most efficient number of linear accelerators per site. Unless there were two to three linear accelerators per facility, services were inefficient, but that did not stop the states paying for stand-alone facilities in regional Australia. The states tried to justify this by repeatedly reviewing the viability of stand-alone radiation oncology facilities. In the end, communities that wanted a single linear accelerator got it, which may have been good politics, but was bad economics.[5]

Thus, the MBS establishes the most efficient use of time and equipment; in other words, it establishes service capacity. Having determined capacity, what is a reasonable daily throughput of services? Getting the throughput figure wrong either enables the situation that occurred in the early days of pathology service pricing, or makes unreal demands so that the only viable option is a publicly provided service with consequent rationing; namely, waiting lists. At the same time, all jurisdictions add multiple layers of extra requirements for many medical services in the name of quality, regulation and reporting, all of which add complexity and cost, but receive scant recognition in the pricing formulae.

Whether it be radiotherapy or general practice, the same rules apply. The MBS has grown enormously since the radiation oncology example. In the absence of countervailing forces, the government can just set the prices; it can ration, irrespective of any outside advice. Look at the Relative Value Study of the MBS, which ran for a number of years up to 2000;[6] for what outcome? It was widely acknowledged that the time taken to complete the Relative Value Study delayed MBS fee increases by several years and saved the government a considerable amount of money.

The taskforce faces no easy task

The MBS Review Taskforce must consider clinical outcomes. Improvements in technology have influenced Medicare pricing, but whether technology improves clinical outcomes may be the subject for a different forum. Adam Elshaug, a member of the Taskforce and Director of the Value in Health Care Division at the Menzies Centre for Health Policy, may well be the person to chair such a forum. He seems to know what he is talking about, having led a study that identified at least 150 health care procedures of low value.[7]

Bruce Robinson, you are not alone in dealing with the Medicare behemoth; it is just that the medical profession would like to be considered. They would like a dividend, be it financial, organisational or social. Without this, doctors may well keep increasing their fees, which will become increasingly distant from the government price, the so-called fee for Medicare benefit paid for the same item of service.

Being marooned with a ration of hard tack is not politically palatable, especially for a patient with cataracts, a dodgy hip and a heart in search of a pacemaker.

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References are available online at www.mja.com.au.

1 Australian Government Department of Health. Medicare Benefits Schedule Review Taskforce. Canberra: Department of Health, 2015: 31 July. http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce (accessed Aug 2015).

2 Korner N. National Association of Medical Specialists — a failed Horatius. Australian Academy of Medicine and Surgery, 2000. http://www.aams.org.au/contents.php?subdir=library/history/&filename=nat_assn_med_spec (accessed Aug 2015).

3 Alexander H, Medew J, Harrison D. Doctors' fees under the microscope amid accusations of over-diagnosis. Canberra Times 2015; 24 Jan. http://www.canberratimes.com.au/national/health/doctors-fees-under-the-microscope-amid-accusations-of-overdiagnosis-20150122-12w2yz (accessed Aug 2015).

4 Australian Government Department of Health. Radiation Oncology Health Program Grants Scheme — guidelines. Section 5.2: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-roi-hpg-rohpg-guidelines (accessed Aug 2015).

5 Acil Consulting. Review of radiotherapy services Victoria. Melbourne: Department of Human Services, Victoria, 1998. http://ncp.ncc.gov.au/docs/Victorian%20review%20of%20radiotherapy%20services,%20April%201998.pdf (accessed Aug 2015).

6 Australian Government Department of Health. Relative value study. Canberra: Department of Health, 2008. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-rvs-overview.htm (accessed Aug 2015).

7 Elshaug A, Watt A, Mundy L, Willis CD. Over 150 potentially low-value health care practices: an Australian study. Med J Aust 2012; 197: 556-560. https://www.mja.com.au/journal/2012/197/10/over-150-potentially-low-value-health-care-practices-australian-study ■