MBS Review

Consumer Engagement Resource

1.   Contents

Version Control

Version	Date	Changes / Amendments
Version 1.5	15 December 2016	Initial conception – drafted by MBS Consumer Panel
Version 1.6	27 January 2017	Proof read amended errors
Version 1.7	20 February 2017	Updated definitions / terminology to align with NHMRC / CHF agreed statement
Version 2.0	30 December 2017	Updated from Induction pack to Consumer Engagement Resource under the guidance of MBS Review Consumer Panel

How to use this document

This document is intended to be used as a resource for clinical committees and secretariat personnel during the MBS Review. It is of particular relevance to consumers on committees; it will also assist MBS Review committee chairs and secretariat personnel to guide consistent, evidence-informed consumer engagement in the Review.

This document should not be distributed for purposes outside of its intended use.

Acknowledgement

The MBS Review Taskforce, Department of Health and Consumer Panel acknowledge the traditional custodians of the lands, seas and waters now known as Australia and express our respect to elders past and present. We acknowledge that the land and the law, language and culture are as important today as they have always been to Aboriginal and Torres Strait Islander people and are integral to health and wellbeing.

Introduction

This resource has been developed by the MBS Review Consumer Panel and Secretariat to support high quality, evidence-informed consumer engagement in the MBS Review. It is a living document: the Panel and Secretariat will update the information to include new tools, processes, evidence and practical suggestions from Review participants.

The resource will be of particular interest to committee chairs and consumers as they work with other committee members and the Secretariat to ensure consumer and community needs and preferences are sought, accessed, analysed and incorporated into Review reports.

In developing this resource, the Panel and Secretariat are mindful of contributing to Taskforce reporting on consumer engagement within the Review and making recommendations in accordance with the Panel's mandate to support the work of Taskforce Committees and to address systemic improvements in the MBS. For further information and suggestions for inclusion in this resource contact the Consumer Panel and the Secretariat at: MBSTaskforceCommittees@health.gov.au

Executive Summary

The MBS Review

On 22 April 2015, the Minister of Health Aged Care and Sport, The Hon Sussan Ley announced that a Medicare Benefits Schedule (MBS) Review Taskforce would be established to undertake a clinician-led review of the more than 5,700 items on the MBS. The Taskforce is looking at how the items can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce appoints clinical committees comprising clinicians and consumers. The committees review items from a specific area of care, for example respiratory (breathing) care. Each committee sends their recommendations to the Taskforce. The Taskforce reviews the recommendations, undertakes public consultation and then sends their final recommendations to the Minister.

Consumers and the MBS Review process

The Taskforce appoints consumers to each of its committees – and sometimes their working groups, to provide an independent consumer perspective to the items being discussed. The Taskforce's Consumer Panel addresses strategic consumer issues that arise in the Review and supports consumers on committees as requested.

Practical examples

This resource has been developed by the Consumer Panel to assist consumers and committee chairs, and clinical and secretariat members, to include consumer perspectives in deliberations and decisions. The resource details processes and templates, checklists and key questions. There are also examples of consumer components in Taskforce and public consultation reports.

1. About the Medicare Benefits Schedule (MBS) Review

1.1 About Medicare

The Australian Government's funding contributions include a universal public health insurance scheme, Medicare. Medicare was introduced in 1984 to provide free or subsidised treatment by health professionals such as doctors, specialists and optometrists.

The Medicare system has 3 parts: hospital, medical and pharmaceutical. The major elements of Medicare include free treatment for public patients in public hospitals, the payment of benefits or rebates for professional health services listed on the Medicare Benefits Schedule, and subsidisation of the costs of a wide range of prescription medicines under the Pharmaceutical Benefits Scheme. A person can have Medicare cover only, or a combination of Medicare and private health insurance coverage.

The government-funded schemes and arrangements aim to give all Australians access to adequate, affordable health care, irrespective of their personal circumstances. The schemes are supplemented by social welfare arrangements, such as smaller out-of-pocket costs and more generous safety nets for those who receive certain income-support payments.

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicarebenefits-index.htm

1.2 About the MBS Review

On 22 April 2015, the Minister of Health Aged Care and Sport, The Hon Sussan Ley announced a program of work to deliver a Healthier Medicare and announced that a Medicare Benefits Schedule (MBS) Review Taskforce would be established. The Taskforce is considering how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe. The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

    Affordable and universal access

    Best practice health services

    Value for the individual patient

    Value for the health system.

The Review is clinician-led and must engage and meet the needs and preferences of patients, consumers and patient and consumer organisations.

http://www.health.gov.au/internet/main/publishing.nsf/content/mbsreviewtaskforce

MEDICARE BENEFITS SCHEDULE REVIEW PROCESS

Government establishes MBS Review Taskforce
Following feedback from clinicians and the broader community that some services on the MBS did not reflect clinical best practice.

The MBS Review Taskforce
The Taskforce is considering more than 5,700 items on the MBS. They are looking at how the items can be aligned with contemporary clinical evidence and practice and improve health outcomes for all Australians.

Taskforce sets up Clinical Committees
The clinical review of MBS items is carried out by discipline specific Clinical Committees and Working Groups. The Clinical Committees who have responsibility for reviewing a defined range of existing MBS items report to the Taskforce.

Taskforce establishes a Principles & Rules Committee
The Principles and Rules Committee appointed by the Taskforce is reviewing the enforceable rules and regulations underpinning the MBS ensuring they are up-to-date and support contemporary clinical practice.

Public Consultation
Committees release reports with draft recommendations and invite stakeholder feedback. The recommendations do not represent the final position on items. They remain subject to consideration of stakeholder feedback and the Taskforce. The Taskforce will continue to release draft recommendations on different areas of the MBS regularly over the next year.

Taskforce committees consider public feedback
The Taskforce Committees will assess the advice from public consultation and decide if any changes are needed to the recommendations The Taskforce Committees will then send the recommendations to the MBS Taskforce.

Taskforce considers committee's recommendations and public feedback
Public consultation with stakeholders, including consumers of MBS services is integral to the process established by the MBS Review Taskforce. The Taskforce will consider the recommendations as well as the information provided by the public to make sure that all the important concerns are addressed.

The Taskforce delivers finalised recommendations to government throughout the MBS Review process & will deliver a final report to government at the end of the MBS Review.
The Taskforce will also develop an ongoing system of review to make sure the MBS remains up-to-date after the current Review is completed.

Government considers Taskforce recommendations

A better MBS for all Australians

What is the Medical Benefits Schedule (MBS)?

The MBS is a list of health professional services subsidised by the Australian Government. There are over 5,700 MBS items which provide patient benefits for wide-ranging services including consultations, diagnostic tests and operations.

1.3 Goals of the MBS Review Taskforce

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

Affordable and universal access—The evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic with some rural patients being particularly under-serviced.

Best practice health services—One of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base where possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.

Value for the individual patient—Another core objective of the Review is to have a MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.

Value for the health system—Achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

Broadly, the Taskforce's focus is on reviewing the existing MBS items, with an initial emphasis on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief there is considerable scope to review and advise on all aspects which would contribute to a modern, transparent and responsive system. This includes not only making recommendations about new items or services being added to the MBS, but also about a MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach and seize this unique opportunity to recommend changes to modernise the MBS on all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. Another key project for the Taskforce will be the development of a mechanism for the ongoing review of the MBS once the current Review is concluded.

1.4 Clinical Committees

Clinical Committees are established by the Taskforce to review allocated parts of the MBS. Members are appointed in their individual capacity, not as representatives of their professional, consumer or other organisations. Committees typically include medical specialists from relevant discipline groups, other clinicians (including those in related disciplines and generalists), experts in evidence evaluation, and consumer representatives. The membership structure is intended to ensure that a broad range of skills and perspectives are considered including specific content knowledge, wider content and practice knowledge, expertise in evidence appraisal and the needs and perspectives of consumers.

1.5 Principles and Rules Committee

The MBS Principles & Rules Committee looks at whether the Medicare laws and rules are working as they should for the Australian public. Its scope encompasses the MBS and the Review as a whole.

1.6 Consumer Panel

In June 2016 a meeting was convened of the MBS Review Taskforce, Committee consumer representatives and CHF. A report from this group informed the Taskforce's decision to appoint a Consumer Panel to support evidence-informed consumer engagement throughout the MBS Review. Like the Principles and Rules Committee, the scope of the Consumer Panel encompasses consumer needs and preferences in the MBS and across the Review.

The Panel has been established to support the work of Taskforce Committees and address systemic improvements in the MBS. Its membership comprises consumers from clinical committees and a clinician from the Taskforce. The Panel's work encompasses:

- Information, training and support for consumers on MBS Review committees.
- Information for all committee members about effective consumer engagement.
- Tools to help consumers and other committee members include consumer perspectives in their reports.
- Providing reports and recommendations to the Taskforce about consumer perspectives on the Review and MBS reform more broadly.

The Panel will support consumers on committees, and the Secretariat, to endeavour to ensure that future public consultations include plain language, accessible communications that also target peak consumer and community groups, and support consumer and community comment on Clinical Committee reports.

1.7 Further information

Structure of health systems in Australia, including components of funding, and regulation and compliance: http://www.aihw.gov.au/australias-health/2014/health-system/

Taskforce Committees and their memberships - including the Panel, throughout the Review: http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-committees

The theory of unnecessary tests/treatments: http://www.choosingwisely.org.au/home.

Choosing Wisely Australia® is helping healthcare providers and consumers start important conversations about improving the quality of healthcare by eliminating unnecessary and sometimes harmful tests, treatments, and procedures. The website provokes thought and spurs conversation between clinicians and patients by helping patients choose care that is supported by evidence; not duplicative of other tests or procedures already received; free from harm; and truly necessary.

The website lists identified tests or procedures commonly used in their field whose necessity should be questioned and discussed, the data relates to key elements of the MBS Review.

2. MBS review consumer principles and evaluation

2.1 Consumer principles to guide review deliberations and decisions

The Consumer Panel has developed a working guidance document comprising the following 12 principles to guide consumer-related deliberations and decisions by the Taskforce and its committees.

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 from the Australian Commission on Safety and Quality in Health Care (safetyandquality.gov.au)

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 clinical practice guidelines, each of which has a plain English version.

   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 equality 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 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 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:

- *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 Consumer Panel also noted that:

1. 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.

2. All practitioners in the Review can be considered to have a COI: 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.

2.2 Key questions to inform reflection on consumer engagement and influence

The Consumer Panel has adapted, with permission, questions developed by consumers engaged in co-research developments with the National Health and Medical Research Council. These questions are provided as a tool to inform reflection on the nature and influence of consumer engagement in the MBS Review.

Operational

1. At what stage of the Review was there genuine consumer participation:
   (a) Development of review concept
   (b) Design of review
   (c) Development of methodology and processes
   (d) Recruitment of committee members
   (e) Conducting the review
   (f) Communicating review outcomes

2. As a result of consumer engagement in the review, was there:
   o Improved understanding of consumer needs, perspectives and evidence?
   o Increased focus on consumer needs, perspectives and evidence?

3. Were the review processes interrogated for relevance to patients, consumer and communities?

4. Did the review processes change as a result of consumer engagement?

5. Did accountability or transparency change?

Administrative

6. Did consumers participate in all meetings?

7. Were the meetings held: (i) face-to-face (ii) teleconference (iii) in writing (out-of-session)

8. Were meeting papers provided to consumers in a timely manner and appropriate format?

9. Did the secretariat/committees provide assistance to consumers to help them understand clinical/technical issues relevant to the committees' work?

Financial

10. Were consumers paid a sitting fee comparable to other committee members and were expenses reimbursed?

3. Consumer inputs and checkpoints in the clinical review process

3.1 Consumer input in clinical committees

Clinical committee deliberations regarding updating of items under review are frequently focussed on clinical evidence. Consumers may find that for a considerable time within the meeting, they are listening to, and learning from, debates about clinical safety, quality, efficiency and efficacy. Reference may be made to clinical practice guidelines: consumers can request a copy of relevant clinical practice guidelines. Some clinical practice guidelines have been informed by consumer input and evidence; some may even have a plain language version. More frequently, consumers have had little or no input into guideline development. This means that relying solely on this source of evidence will not address consumer needs and preferences; social and cultural issues; access and equity; and consumer and community acceptability and tolerance.

While the Review is not focussed on fees and costs, consumers are likely to find this is a topic of discussion. Consumers can provide perspectives in relation to the scheduled fee and the impact on private insurance and other out of pocket costs for consumers, as well as the cumulative effect of multiple procedures/fees and non-health specific costs such as transport; work time lost; child care; and the resources needed to try to self-manage and coordinate care.

Consumers may also find that clinicians focus on a diagnosis and/or procedures, an approach which can overlook the fact that consumers have many health issues and move within and between areas and levels of health care.

It is critical that at key points in the review process, the committee considers consumer needs and include those related to access, equity, acceptability, tolerability, continuity and integration of care and outcome.

Committees typically have four or five meetings. The table below identifies typical steps in the committee process and key consumer checkpoints – and tools and templates available to assist with these.

3.2 Consumer checkpoints in the clinical review process

	step 1 Scope the task	step 2 Confirm & action work plan	step 3 Finalise report for Taskforce	step 4 Respond to public consultation
Objectives/ outcomes	1. Introductions and background ✓ Check **Consumer rep role** (enc) 2. Group norms and methods ✓ Check **Consumer reporting template** (enc) 3. Key issues and questions ✓ Check **Consumer key questions** (enc) 4. Extra evidence/data needed ✓ Check **Consumer evidence requests (TBD)**	7. Work plan finalised ✓ Check Consumer input scheduled 8. High priority items reviewed ✓ Check Consumer perspectives integrated 9. Evidence aligned ✓ Check Consumer evidence /specific questions for public consultation	10. Review and refine high priority item recommendations ✓ Check 11. Recommendations for remaining items ✓ Check 12. Evidence aligned ✓ Check 13. Approve report for Taskforce ✓ Check Consumer component of report Recommendations for targeted public consultation	14. Consider feedback ✓ Check Consumer summary 15. Amend recommendations as agreed ✓ Check 16. Submit final report to Taskforce ✓ Check Consumer feedback summaries and recommendations
Additional work items following original task.	5. Prioritisation of items 6. Additional data or evidence compiled by Secretariat	17. Recommendations and rationales drafted on reviewed items	18. Recommendations and rationales refined as necessary ✓ Check Consumer Panel assist with report using the **Consumer communication checklist** (enc) & targeted consultation plan as per the **Framework for targeted public consultation** (enc)	19. Public dissemination ✓ Check **Consumer Panel** advises targeted & public communications

3.3 Consumer communications checklist

Executive Summary	Yes	No	Changes
This is in plain English and I understand it			
I can identify the key recommendations			
I can understand the scope of items reviewed			
I can understand how consumers were considered by this committee			
Consumer Impact Statement	**Yes**	**No**	**Changes**
This is in plain English I understand			
I can understand how consumers were engaged by this committee			
I understand the impact to consumers by these recommendations			
I can clearly understand the message and explanations here			
Consumer Summary Table	**Yes**	**No**	**Changes**
The style is consistent			
The recommendations are easy to follow and I can easily link the numbering back to the body of the report			
Overall Report	**Yes**	**No**	**Changes**
I can easily identify which items were reviewed in this report			
I can understand what the committee is recommending			
I understand the rationale behind the recommendations made.			
The supporting evidence clear to me			
Additional Comments/Changes			
1. Page XX section XX **2.** Page XX section XX **3.** Page XX section XX			

3.4 Seeking consumer opinion on committee work

During a consumer's time on a clinical committee they are appointed as an individual and are not required to speak on behalf of the views of organisations or focus groups. They are entitled to research their views and promote consumer opinion as long as they do not breach confidentiality requirements of the committee. The Secretariat can provide advice about what information can be shared and with whom. With their advice, and the committee chair's knowledge, consumers can:

- Speak with relevant groups and organisations to determine the key issues relevant to the subject matter e.g. Breast Cancer Network Australia, Lynch Syndrome Australia, HeartKids Australia.
- Request information from relevant groups and organisations to better understand the context of what is proposed as changes during the MBS Review.
- Encourage relevant groups and organisations to participate in the public consultation and keep them in the loop on release dates.
- Set up regular meetings with other consumers on the MBS Review to establish best practice approaches and a network of support.
- Arrange out of session meetings with the clinical committee chair and/or Secretariat to clarify any terms or actions.
- Work with a mentor or fellow individual consumer within the Review to provide guidance.

3.5 Targeted public consultation

Consumers can also make recommendations regarding patient, consumer and community organisations to be targeted in the consultation process and highlight specific questions and issues on which comment is being sought. The Consumer Panel can assist consumers, their committees and the Taskforce to plan open and targeted community consultation.

One way to group consumer and community organisations, and their constituencies is as follows:
- Patient organisations (eg Asthma Australia)
- Health consumer organisations (eg Consumers Health Forum; Health Consumers Alliance SA)
- Health organisation consumer groups (eg Primary Health Network and Local Health Network consumer advisory groups)
- Consumers appointed to committees for various health bodies eg Australian Health Practitioner Regulation Agency and the Australian Commission on Safety and Quality in Health Care

- Organisations that represent populations, for example by age, (dis) ability, gender, family circumstance, socioeconomic income, sociocultural group, socioeconomic circumstance, geographic location/distance from & access to services
- Government agencies and authorities – state and commonwealth.

It is critically important to be able differentiate:
- Genuine individual and consumer group/population-based feedback
- Feedback that is not from consumers/community members
- Feedback that purports to be from consumers and has been facilitated by others for example industry groups that have a commercial interest in the matter.

4. Consumer recruitment, role and expectations

4.1 Consumer recruitment for MBS Review committees and working groups

The MBS Review Taskforce has an ongoing and open nomination process. Nominations for participation on committees and working groups are accepted anytime via the Department of Health website. This open and transparent nomination process is integral to the Review process.

The review of MBS items is carried out by clinicians, consumers and health system experts through discipline specific Clinical Committees and Working Groups and the Principles and Rules Committee. These Committees report to the Taskforce who have responsibility for reviewing a defined range of existing MBS items.

In order to recruit higher numbers of consumers at key times during the Review with specific skillsets, (for example when new tranches of clinical committees are being established), the Department may enlist the expertise of other organisations which have unique knowledge of consumer skills and background, and previous experience.

4.2 Role of consumers

Consumers support the Clinical Committee in achieving the MBS Review goals by:

- Participating in committee meetings and deliberations to identify where changes are required to MBS items.

- Providing consumer perspectives and engaging in the committee's decision-making, including at key checkpoints (see below).

- Assisting in pointing out where item descriptors can be written in a way that is understandable to patients yet still reflects the technicalities of the procedure undertaken; this will help patients to understand what procedure they had.

- Challenging the clinicians about what is accepted practice yet may not seem appropriate to outsiders, for example why anaesthetists have so many add on fees as part of their Relative Value Guide.

Formation of recommendations to the Taskforce:

- Providing input into the Clinical Committee reports to ensure they are in plain English and reflect the consumers' perspectives on the services funded under the MBS. These views are included in final reports to the MBS Review Taskforce and recommendations to the Health Minister.

- Evaluating MBS items in the scope of the Clinical Committee, including the findings from working groups and articulating consumer perspectives via the Clinical Committee to the Taskforce.

4.3 What consumers on committees can expect

Consumers can (generally) expect to:

- Be involved throughout the duration of the Clinical Committee, approximately 6 months, though in some instances it may be much longer.
- Participate in a face to face induction meeting.
- Participate in two face to face meetings of 4-8 hours at the beginning and end of the committee process.
- Participate in four to five teleconferences - approximately two to three hours per teleconference (once a month) over the period of the Clinical Committee.
- Read the agenda papers and research reports to understand the committee's deliberations.
- Be asked, along with other committee members, to undertake additional writing tasks and/or comment on documents. There is generally no additional sitting fee for this work.
- Bring an essential community perspective to committee deliberations, and do so in accordance with the evidence regarding the imperative for co-design in health policy and research. Consumers are not expected to have clinical expertise.
- Be paid sitting fees for the time spent attending the clinical committee in person and via teleconference, as per Specified Professional Committees in Table 4 of *Determination 2015/20* and as determined by the Remuneration Tribunal. This payment encompasses payment for reasonable preparation and follow-up in relation to each meeting.

5. Support and guidance for consumers on committees and working groups

5.1 Information and support

Information, induction and training

National and local consumer organisations offer a range of information, education, training and support for health consumers. The national peak health consumer organisation, the Consumers Health Forum of Australia (chf.org.au), has a free online introduction to consumer representation resource:

http://elearning.ourhealth.org.au/guidelines/

When you are appointed to a committee, you will be provided with an induction pack and invited to participate in an induction session.

Getting information about the process

When you are appointed, you will be introduced to the Chair of your committee and members of the department's Secretariat for the MBS Review.

You can contact your nominated Secretariat member(s) with any questions about the work including meeting papers and arrangements.

You can contact your chairperson to discuss any questions or concerns regarding your roles and responsibilities on the committee.

Support from experienced consumers

The Consumer Panel maintains a list of experienced MBS Review consumers who are willing to act as a mentor – or just have a chat – with consumers new to their role with the Review.

Further information about national health consumer advocacy and representation the website of the Consumers Health Forum of Australia (chf.org.au) is the national peak body representing the interests of Australian healthcare consumers. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

5.2 Examples of questions to focus consumer perspectives in reports

The following questions can be used by committee chairs, consumers and others to focus deliberations and reporting on consumer perspectives. The Consumer Panel welcomes suggestions to further develop this list of questions to support the work of the Taskforce and its committees.

Safety

- Is this item currently used safely? How do we know?
- If this item were removed from the MBS would it impact positively or negatively on patient safety?
- Are there any special needs patient groups for whom the normal relative safety considerations are different because of personal or life circumstance (e.g. rural and remote communities, patients with cognitive impairment)?
- Is there any condition that could be placed on, or removed from, the use of this item that would increase the safety of its current use?
- Is there a safety issue about this item that would make it more appropriate to also fund an assistant?

Quality

- Does use of this item produce high quality care?
- Is the item related to care that is acceptable, preferred and tolerable?
  Is there a condition that could be placed on, or removed from the use of this item that would increase the level of quality associated with its use?
- Are there any special needs patient groups for whom the normal quality considerations are different (e.g. rural and remote communities)?
- Is there a safe level of practice e.g. less than 25 times per year?
- Are there clinical guidelines that cover this item and if there is, is the item consistent with the Guidelines? If not, what evidence is used to support this item?
- Are the changes that are recommended consistent with improvements in high quality care?

Access

- Is there any patient group who should have access to this item but either don't have access or have inappropriately limited access? How can this be remedied?
- Is this item used in patient groups who are unlikely to receive benefit from its use?
- Is there a condition that could be placed on this item that would improve appropriate access to this item?
- Are there any special needs patient groups for whom the normal effectiveness considerations are different (e.g. rural and remote communities, people with acquired brain injury)?

Effectiveness

- Does this item produce the benefits expected for the patient groups in whom it is used?
- Is there a condition that could be placed on access to this item that would increase effectiveness by limiting inappropriate access?
- Are there any special needs patient groups for whom the normal quality considerations are different (e.g. rural and remote communities, people with acquired brain injury)?

Cost Effectiveness

- Does this item deliver value for money when the costs are compared to the benefits?
- Is there a condition that could be placed on access to this item that would increase cost effectiveness by limiting inappropriate access?
- Are there out-of-pockets associated with this item? And if so, is it because it is under remunerated?
- What is the impact on out-of-pocket costs?
- Are there any special needs patient groups for whom the normal relative cost effectiveness considerations are different (e.g. rural and remote communities, people with acquired brain injury)?

5.3 Hints and tips for consumers on committees

The following hints and tips have been provided by consumers currently on MBS Review clinical committees. The Consumer Panel welcomes additions to the list.

- Ensure you have spoken with the committee chair before the first meeting and have a shared understanding of your role, and how the committee will address and incorporate consumer perspectives.

- Ask for hard copies of the meeting papers if you prefer this. Some timelines are tight so make sure you let organisers know well beforehand of your preference.

- Have your key points/comments ready on the material provided for the agenda and follow-up with an email if you think this will assist the committee.

- Speak from your role as a consumer – you are not expected to have clinical expertise.

- Acknowledge the limits of your knowledge of consumer perspectives on a given issue – wider feedback can be sought if needed.

- Focus on positive solutions that meet the needs and preferences of all patients and carers.

- If you need to ask a question – ask it, and if you don't agree, have this recorded.

- Ask for an explanation if you need to understand, to undertake your role. Consider asking the Secretariat for information/explanation before the meeting so meeting time can be spent on discussion and decision-making rather than explaining information.

- Take notes of discussions and outcomes so you can read minutes carefully for errors or omissions. Consider summarising the key points you made in a meeting and sending them to the person documenting the minutes, to support an accurate record of consumer perspectives.

- Get to know other participants as opportunity allows, for example in break times at face to face meetings.

- Speak from a general perspective, for example 'those experiencing… experienced…'. Don't personalise (for example 'when I had… I experienced…')

- Let the Secretariat know if you would like some support from another consumer: often you can be connected to someone who is experienced and/or currently undertaking a similar role.

Appendix A – Consumer-related terminology

The MBS Review uses a number of clinical terms that have a specific meaning in the MBS context: the Secretariat can explain these terms to committee members. The following terms and definitions relate specifically to patients, consumers and the community, as applied in the Review.

Community

A group of people sharing a common interest (e.g. cultural, social, political, health, economic interests) but not necessarily a particular geographic association. Different types of communities are likely to have different perspectives and approaches ….

National Health and Medical Research Council (2016): *Statement on Consumer and Community Involvement in Health and Medical Research* www.nhmrc.gov.au/guidelines/publications/s01

Consumer

Patients and potential patients, carers, and people who use health care services.

Collectively, 'consumers' and 'community members' may be referred to as 'the public'.

The Australian Commission on Safety and Quality in Health Care definition: members of the public who use, or are potential users of health care services - patients, consumers, families, carers and other support people.

National Health and Medical Research Council (2016) Statement on Consumer and Community Involvement in Health and Medical Research www.nhmrc.gov.au/guidelines/publications/s01

Patient

A person receiving medical services because of a problem or a check-up.

deBronkart D (2013). 'Let patients help': *A "patient engagement" handbook-how doctors, nurses, patients and caregivers can partner for better care'* epatientdave.com/let-patients-help/

Carers

Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged.

Carers Australia @ carersaustralia.com.au

Consumer representative

Someone who voices consumer perspectives and takes part in the decision-making process on behalf of consumers. This person may be nominated by, and may be accountable to, an organisation of consumers. This consumer representative however may have a narrower view as they are speaking on behalf of their organisation and not necessarily that of the wider community. A consumer representative may be appropriately trained or may undergo training and be supported to advocate for consumer-centred health care.

National Health and Medical Research Council (2016): *Statement on Consumer and Community Involvement in Health and Medical Research* www.nhmrc.gov.au/guidelines/publications/s01

Consumer-or person- or patient- centred care

Patient or consumer centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers and identifies four key principles of patient centred approaches:

- Treating patients, consumers, carers and families with dignity and respect;
- Encouraging and supporting participation in decision making by patients, consumers, carers and families;
- Communicating and sharing information with patients, consumers, carers and families;
- Fostering collaboration with patients, consumers, carers, families and health professionals in program and policy development, and in health service design, delivery and evaluation.

Australian Commission on Safety and Quality in Healthcare @ safetyandquality.gov.au

Health literacy

Individual health literacy is the knowledge, motivation, skills and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care, and make appropriate decisions.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that have an impact on the way in which people access, understand, appraise and apply health-related information and service.

Australian Commission on Safety and Quality in Healthcare @ safetyandquality.gov.au

Public participation

Any process that involves the public in problem-solving or decision-making and that uses public input to make better decisions

International Association of Public Participation @ iap2.org.au

IAP2 PUBLIC PARTICIPATION SPECTRUM

INCREASING LEVEL OF PUBLIC IMPACT

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Public Participation Goal:	**Public Participation Goal:**	**Public Participation Goal:**	**Public Participation Goal:**	**Public Participation Goal:**
To provide the public with balanced and objective information to assist them in understanding the problems, alternatives and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
Promise to the Public:	**Promise to the Public:**	**Promise to the Public:**	**Promise to the Public:**	**Promise to the Public:**
We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
Example Tools:	**Example Tools:**	**Example Tools:**	**Example Tools:**	**Example Tools:**
• fact sheets • web sites • open houses.	• public comment • focus groups • surveys • public meetings.	• workshops • deliberate polling.	• citizen advisory committees • consensus-building • participatory decision-making.	• citizen juries • ballots • delegated decisions.

Healthcare rights

Principles of client-centred care and health rights are enshrined in the *Australian Charter of Healthcare Rights* (http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/), endorsed since 2008 by all Australian Health Ministers. The Charter outlines three healthcare principles:

1. Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2. The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3. Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences and seven rights:

MY RIGHTS	WHAT THIS MEANS
Access I have a right to health care.	I can access services to address my healthcare needs.
Safety I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

Clinical Practice Guidelines (CPGs)

Clinical Practice Guidelines are statements that include recommendations intended to optimise patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. They are different from other sources of health information because they present recommendations about what should or should not be provided or done, something that other sources of information do not generally do. Since many of these recommendations will directly affect the care received by patients and the public, it seems natural that efforts should be made to produce guideline-derived

materials that are meant to be used by patients and the public to support their health care decisions.

The adequate application of a guideline does not only imply strict adherence to guideline recommendations but also reasonable non-adherence due to a patient's individual preferences or circumstances. It is crucial that guidelines convey this idea to both physicians and patients and provide information to facilitate decision making the importance of presenting recommendations that relate to self-management was one of the strongest messages (from patients and the public)…relatively few patient versions in the English language currently meet this need.

Guidelines International Network (GIN) Public Toolkit (2015) @.g-i-n.net

Note: Guidelines in some areas are difficult to access because of software incompatibility.   It is important to ask for the Guidelines appropriate for your Committee

Transparency in healthcare

The free, uninhibited flow of information that is open to the scrutiny of others

National Patient Safety Foundation, Boston 2015

Value in healthcare

Where would we start if care and support were person-centred?

- We would start by understanding what matters to the patient.
- Every encounter would be one which embraces the patient as person rather than object.
- We would explore their health beliefs, motivations, knowledge, skills, learning styles and familial and social context as well as according to their disease and demography.
- Interventions would be targeted and tailored based on these insights to support people where they are at to achieve their goals.

[We would] measure:

- How far people's preferences are supported.
- How confident and able people are to manage their long-term conditions better.
- The extent to which the NHS has been successful, working in partnership with others such as social care, housing and the voluntary sector, supporting people to achieve their outcomes.

The Health Foundation (2014). 'In brief; person-centred care from ideas to action' @ health.org.uk

Appendix B - A consumer perspective on evidence

MBS Review Consumer Panel, April 2017

Introduction

The Consumer Panel are keen to understand how evidence is utilised, what impact/influence is placed on consumer evidence, and how clinical evidence and other forms of evidence have a bearing on the development of recommendations regarding changes to the Medical Benefits Schedule.

This paper is an attempt to address these issues. It was considered and accepted in draft form by the Consumer Panel at its meeting of 29 March 2017.

Background

- The MBS contains over 5,700 items (not including pharmaceuticals). In 2012, it was estimated that only around 3% of these items had been formally assessed against contemporary evidence of safety, effectiveness and cost-effectiveness. [1]

- The MBS Review seeks, in part, to 'modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base where possible.'

- In general, the inclusion of new items on the MBS may be recommended by the Medical Services Advisory Committee (MSAC). This process develops recommendations based on an analysis of safety, effectiveness and cost-effectiveness, drawing on available clinical evidence, and assessing the relative value of a service against current practice or a comparator. The MBS Review has adopted a different approach to MSAC, through a process of rapid review and clinical assessment. Item descriptors generated by the Review must 'reflect the evidence that has been adduced to support the comparative safety and quality, and cost effectiveness of the service'.

- Committees are also required to appraise relevant evidence, including consumer evidence, such as geographic variations in service delivery and the clinical and financial implications, patient safety and equity considerations.

- Evidence reviews can be requested by committees. This evidence is collected using a combination of Departmental and external resources and using a rapid review methodology. MBS data is compiled by the Department. Literature reviews are typically conducted by an external health technology assessment group contracted by the Department. Where relevant, the clinical committee may consult with external experts.

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[1] Medical Benefits Review Task Group. Development of a quality framework for the Medicare Benefits Schedule. Discussion paper/ Canberra: Australian Government Department of Health and Ageing, 2010.

- The Consumer Induction Pack identifies common points in committee and working group processes for evidence and consumer checks.
- The active involvement of consumers within the MBS Review is consistent with contemporary approaches to evidence based review. This approach acknowledges the development of sophisticated hierarchies of evidence, and recognises the crucial role of patient values and preferences in clinical decision making.[2]

Clinical Practice Guidelines (CPGs)

CPG's are sets of non-mandatory rules, principles or recommendations for procedures or practices in a particular field. They only become mandatory if governments legislate them, professional bodies incorporate them into codes of conduct for their members or funding bodies insist on compliance. In the clinical, public and environmental health fields, the National Health and Medical Research Council (NHMRC) guidelines provide the evidence-based information needed to achieve best practice.

MBS Items do not currently including references to relevant CPG's in item descriptors. Referencing CPGs in item descriptors would assist providers to confirm the care context of the MBS item. Consumers would see that the item is evidence-based, is not just their clinician's opinion, and provide them with confidence that the services provided reflect accepted best practice.

Referencing CPS's also enable easy identification of items related to chronic disease management and creates an opportunity to group items in an evidence-informed cycle of care. Such an approach is consistent with principles of informed consent and shared/supported decision-making.

Evidence has demonstrated the value consumer representation can bring to this process.[3] The Consumer Panel supports the inclusion of consumer representatives in the development and review of CPG's.

Accessing and understanding whether or not guidelines are available and current can sometimes be difficult. The NHMRC offers a search facility that contains approved guidelines. This can be accessed at the National Health and Medical Research Council Clinical Practice Guidelines Portal - www.clinicalguidelines.gov.au.

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[2] Djulbegovic B, Guyatt GH, Progress in evidence-based medicine: a quarter century on. The Lancet 2017 http://dx.doi.org/10.1016/SO140-6736(16)31592-6

[3] When Patients Write the Guidelines: Patient Panel Recommendations for the Treatment of Rheumatoid Arthritis Fraenkel L et al, Arthritis Care & Research Vol. 68, No. 1, Jan 2016, 00 26-35

Data to inform decision-making

Although improvements to safety, quality and cost effectiveness are stated objectives of the MBS Review, for consumer representatives the biggest challenge is ensuring the availability (predominantly affordability) of services for people who clinically need them.   There is evidence that patients and clinicians often over-estimate the benefits of procedures. Further, evidence based medicine has evolved to recognise the importance of patient's values and preferences through shared decision making.

One of the historical weaknesses in effective consumer representation has been the lack of availability of good robust data to inform and support consumers in making decisions about services they are offered. The MBS Review has the significant advantage for consumer representatives of access to the MBS claiming data, which provides accurate and up-to-date information about use of specific MBS items. When combined with good clinical guidelines the opportunity for *informed consumer engagement* begins to take form.

Data informed tools include:

- Gross usage: Comparisons between the volume of usage of specific items with the volume of usage projected in clinical guidelines e.g. the number of people who have an MRI of the knee for osteoarthritis when clinical guidelines recommend a simple x-ray. Data can be used to measure effectiveness, and identify overuse, misuse and waste.

- Care pathways: Compare the MBS claiming pathway with clinical guidance pathways to determine if there is significant over or under use of specific items or avoidable duplication. For example, it is possible to analyse whether a consumer who has a Stress Echocardiogram has recently had a Stress ECG, and whether they go on to have a CT Angiogram and/or revascularization. This provides evidence as to the effectiveness of a Stress ECG in identifying blood vessel occlusions and whether it should be included excluded as the first diagnostic test for someone with suspected coronary disease. It also allows examination of the optimum pathway of a person requiring revascularization both from a cost and time to intervention perspective.

- Geographic variation: Determine geographic patterns of use that may highlight some groups who over or under use a specific item e.g. consumers living in rural or remote locations may have an increased number of ECGs or Holter Monitors because more effective testing like a Stress Echocardiogram is not available. It can also be used to research the effect of reduced access on health outcomes in targeted geographic areas e.g. where CT Angiogram is not available in a rural or remote setting, the increased mortality rate from coronary disease.

- Project Effect of Proposed Changes: Determine (to a limited degree) how changes to the MBS will affect appropriate access to specific items e.g. limiting the number of ECG echocardiograms a patient can have in a twelve month period needs to have a sensitivity built in that takes into account factors such as:
    - People who may have a sudden deterioration in their condition,
    - The first test used poor equipment or a variation in technical expertise may require a repeat test, or
    - A person may have a timing issue due to the necessity to travel a long distance from home to have a test conducted.
- New health statistics to build the evidence base: The OECD Health Minister's meeting on 17 January 2017 identified the development of new statistical tools to assess the experience and outcomes of patients to better equip policy makers with data to design and co-ordinate health systems that reflect what matters for patients, particularly for example, in the area of chronic disease.[4] The Australian Commission on Safety and Quality in Health Care is undertaking a program of work in the area of patient reported outcomes.[5]

Transparency: In making decisions about health services, consumers require access to information about benefits, risks, alternatives and costs. Consumers frequently lack sufficient information to make an informed choice, or to challenge health professionals in relation to the costs they are likely to bear, and potential alternative courses of action. This would help overcome the tendency to overestimate the benefits and underestimate the harms of treatments.[6] The availability and use of MBS data will also enable ongoing monitoring of patterns of use of MBS services as result of the review.

Although access to data, guidelines and other forms of evidence are not perfect or freely available nor will it and will not address the variation in clinical needs of all consumers it would be a significant improvement for consumers and their representatives who frequently operate in an evidence free zone.

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[4] Caring for Quality in Health: Lessons learned http://www.oecd.org/els/health-systems/health-care-quality-reviews.htm

[5] https://www.safetyandquality.gov.au/our-work/information-strategy/indicators/patient-reported-outcome-measures/

[6] Hoffman TC, Del Mar C. Patients' expectations of the benefits and harms of treatments, screening, and tests: a systematic review. JAMA Intern Med. 2015 Feb;175(2):274-86

Recommendations:

1. MBS Items should contain a reference that includes the date the item was last reviewed, and links to relevant practice guidelines where relevant. Similarly, items added to the MBS through MSAC should be linked to sources of evidence, and provide a clear summary of the changes in outcomes from using the new or revised items to provide information for clinicians and patients on which to base clinical decisions and to support independent analysis and review.

2. The Consumer Panel supports the implementation of rigorous data transparency, and requirements for clinicians to divulge treatment options and their relative costs. This would enable consumers to consider treatment options with their clinicians, and to take any out of pocket costs into consideration when making decisions about their care.

3. The Consumer Panel acknowledges that evidence is evolving through innovation and technology, demographic changes, improvements in data collection and analysis, changes in clinical practice, policy change, and consumer behaviour. However consumers should be provided with information necessary to assess the quality of the health services they receive. This could include easily understandable and accessible evidence summaries, linked to evidence based patient decision aids which would help patients make evidence informed decisions and obtain answers to questions such as:

1. What are my options (including wait and watch)
2. What are the potential benefits and harms of those options?
3. How likely are each of the benefits and harms to happen to me?

ASK: Ask Share Know - askshareknow.com.au

4. Research is required to identify the most appropriate implementation strategies to improve the level of engagement between patients and clinicians.

The clinical profession should be supported to engage with consumers as partners in care. This includes the development of mechanisms to inform and guide clinicians in engaging with consumers on aspects of safety, costs and clinical outcomes. These mechanisms should be aimed at dispelling the myth that there is a relationship between charges and quality and arming consumers to make informed choices.

Appendix C - Clinical Reports: Content for consumers

Within the clinical reports consumers on committees have three important sections to check; initial writing of these sections may be complete by Secretariat:

1. 'Consumer engagement and key impacts', which outlines how consumers were engaged in and influenced the work of the committee

2. 'Key consumer Impacts' which explains how consumers are likely to be affected by the recommended changes; and

3. 'Summary table of committee recommendations' which gives a plain English explanation of the changes to the item numbers based on the recommendations.

All consumer content should be written following the templates and with input from consumers on the Clinical Committee and/or Working Groups.

C1 Template - Consumer engagement and key impacts

The Committee believes it is important to find out from consumers if they will be helped or disadvantaged by the recommendations – and how, and why. Following the public consultation the Committee will assess the advice from consumers and decide whether any changes are needed to the recommendations. The Committee will then send the recommendations to the Taskforce. The Taskforce will consider the recommendations as well as the information provided by consumers in order to make sure that all the important concerns are addressed. The Taskforce will then provide the recommendation to government.

This section summarises the report's key recommendations from a consumer perspective. It aims to make it easier for health consumers and members of the general public to understand and comment on the report's recommendations. Additional information written in plain English—including a full list of all the items and their accompanying recommendations—can be found in each report's content– Summary Table of Committee Recommendations (page *insert text*).

The Committee examined how well the descriptions *of [enter number of items] MBS* items matched current clinical practice and met the needs of Australians. The Committee brought together consumers and practitioners with experience in and commitment to [*insert]* including [*List members on panel i.e. specialists, GPs, allied health professionals, pathology*]. All recommendations are provisional and may be revised based on feedback received during consultation.

The Committee made the following recommendations with the aim of [*insert committee's key objectives*]:

Δ   *Insert*

[Delete this section if not relevant] The Committee also recommended restructuring sets of MBS items and revising the descriptors of some MBS items (i.e., replacing out-dated descriptions of treatment delivery):

Δ   *Insert*

Committee chairpersons and consumers can request assistance from the Consumer Panel and the Secretariat to complete the consumer perspectives component of their reports. The Panel may also consider reports within the context of the whole Review and comment on:

- Consistency across other reports and the Review;
- Plain English language used;
- Clarity re the scope and purpose of the report ;
- Logic and ease of understanding all recommendations and their potential consumer impact ;
- Ease of understanding the report and its consumer impact, as a whole.

C2 Example of a consumer impact report - Dermatology Clinical Committee

This section summarises the report's key recommendations from a consumer perspective. It aims to make it easier for health consumers and members of the general public to understand and comment on the report's recommendations. Additional information for consumers can be found in the Consumer Summary table.

The Committee considered 38 MBS item numbers relating to dermatology, allergy and immunology. The majority of these items cover the treatment of potential skin cancers and associated conditions. A small group of allergy testing items were also included. In recommending changes, the Committee focused on encouraging best practice treatment, improving consumer care and safety; and ensuring MBS services provide value for consumers and the healthcare system. The Committee's membership included specialists, GPs and a consumer.

The Committee considered that no changes were required to three items, which provide current and medically appropriate treatment. A further seven items have been recommended for deletion. In particular, this includes deleting several out-dated items covering the removal of warts, skin cancers and other lesions by cutting, which are no longer considered best practice. Alternative treatment options, such as freezing, are already covered in the MBS. In many cases, these items are no longer used, with no or almost no claims made against them in recent years.

The Committee recommended changes to 28 items. Generally, these changes include updating the item descriptions to reflect best practice medical treatment, and providing more detailed guidance for medical practitioners on appropriate use of the items. In some cases, this included providing more stringent safety guidelines, such as requiring specialist medical opinion prior to treatment, or limiting the number of times an item can be claimed for safety reasons (such as limiting potential radiation exposure for patients). One particular area where changes are recommended to reflect best practice treatment include modernising and updating laser-based treatments for skin cancers and other lesions to include additional types of lasers, and to ensure that laser equipment is appropriately certified. Some items were also recommended for removal and/or consolidation with existing items because they were considered to be potentially misused or to provide low value care. This included bulk treatment items (covering procedures such as the removal of more than 10 malignant lesions, or the conduct of more than 20 allergy tests at one time), where evidence suggested that these items were being used more often than expected. The Committee was concerned that these items were potentially being used because they allow treatment providers to claim larger rebates, and has recommended that these bulk treatments be merged with existing non-bulk item numbers.

Finally the Committee also recommended that certain items should be split to better reflect the true scope of practice. An example of this is the proposed changes to the allergy items. They would now specify different types of allergy testing that can be conducted, and provide guidance around the qualifications and experience that medical practitioners need to be able to provide the more technical, complex and potentially risky allergy testing items.

C3 Template: Summary table of committee recommendations

This table describes the medical services for which changes have been recommended, the specific recommendation(s) of the clinical experts and the reasons for the recommendation(s). This table summarises the major recommendations of the Committee.

Example only (delete this row once table has been populated)

Item	What it does	Committee Recommendation	What would be different	Why
30493	Diagnostic test that measures the pressure of the sphincter (a ring-shaped muscle that regulates the flow of bile and pancreatic secretions	To remove item 30493 from the MBS	The service will no longer attract a MBS rebate	The service is not supported by the published literature and has no place in contemporary clinical practice.

Recommendation 1 – <mark>*[insert Text]*</mark>

Item	What it does	Committee Recommendation	What would be different	Why

Item	What it does	Committee Recommendation	What would be different	Why

Recommendation 2 – <mark>*[insert Text]*</mark>

Item	What it does	Committee Recommendation	What would be different	Why

Item	What it does	Committee Recommendation	What would be different	Why

Insert more rows as required