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Submission to Report from the Specialist and Consultant Physician Consultation Clinical Committee of the MBS Review Taskforce

June 2019

1. Introduction and overview

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the draft report from the Specialist and Consultant Physician Consultation Clinical Committee of the MBS Review Taskforce (the Clinical Committee).

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, gastro-enterology, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine.

In Australia, the RACP's members practise in a range of health care settings across both the private and public systems from tertiary hospitals through to community-based practice.

The RACP's approach to this and all previous reports released by the MBS Review Taskforce have focused on the impact that the recommendations will have on the capability and capacity of the health system to provide high quality patient care, and ensuring high-value, sustainable and effective care models. This is consistent with the RACP's objectives.

The RACP is not an industrial organisation and the RACP's remit does not extend to commenting on specific quantum amounts in individual MBS items as these issues are more appropriately addressed by bodies with an industrial remit such as the Australian Association of Consultant Physicians (AACP) and Australian Medical Association (AMA). We also note that a number of our affiliated Specialty Societies including the Medical Oncology Group of Australia and the Australasian Sleep Association have made submissions on behalf of their members while others such as the Australian Rheumatology Association are in the process of developing a submission.

Nevertheless, changes to the remuneration structure of MBS items and the incentives that are provided for different types of clinical practice (for example procedural versus cognitive and lengths of consultations) will impact on the care that is provided to patients and this submission will address these issues broadly.

The recommendations to replace the current standard attendance items, in particular the initial and subsequent consultation items, with a time tiered remuneration structure represents a very radical change in approach under the MBS. The RACP acknowledges that there have been significant changes to medical practice since many of the consultation items were first introduced to the Schedule.

There are a range of views among members of the RACP who have provided feedback on the recommendations as to whether the proposed changes will result in the outcomes that the SCPCC Committee have identified, including simplifying the Schedule and supporting contemporary clinical practice. There is a significant risk of unintended consequences arising, including reduced access for longer consultations and higher out of pocket costs.

It is not possible to assess the impact of the proposed recommendations without:

- Clarity as to the rebate amounts for each of the tiers which will indicate the extent to which they will cover the costs of providing the services, hence reducing the risk to patients of incurring out of pocket expenditures
    - Rebates for different time tiers should be set in such a way as to avoid any perverse incentives to inappropriately shorten consultation times, or to favour single disease

management over effective management of multimorbidity and team-based approaches to care;

- Better detail on how complexity will be dealt with – particularly in circumstances where greater complexity does not correlate with a longer consultation time;
- Clarity on whether all necessary activities outside of face to face consultation in the presence of the patient have been adequately compensated for – such as reviewing complex patient medical records and test results etc. This is important because any significant disparity between patient rebates and costs of service provision can result in out of pocket charges for patients which can reduce access to clinically necessary care.

In the absence of the above key information and taking into account the range of views across the RACP membership and the potential for unintended adverse impacts on the ability of patients to access high quality and safe care, **the RACP is not in a position to support or oppose the recommendations**.

Instead this submission provides commentary on the recommendations informed by feedback from individual RACP members, as well as from RACP bodies and affiliated Specialty Societies, on the preconditions for ensuring that any changes to the MBS are consistent with the RACP's vision of an accessible and affordable health system that provides high value, high quality patient care, and promotes better integration across the health sector.

1.1 Consultation approach

To develop this submission the RACP sought written feedback directly from our members, committees and affiliated Specialty Societies, as well as inviting members to respond to an online survey. The on-line survey was distributed to the Australian membership of the RACP (over 20,000) and was open for two weeks, resulting in 566 responses.

The survey asked for our members' views on the following recommendations in the draft report:

- Recommendation 1 - Introduce time-tiered attendance items
- Recommendation 2 – Introduce new attendance items for acute, urgent and unplanned attendances
- Recommendation 5 - Removing consultant physician, geriatric, addiction medicine, and sexual health medicine complex plan items
- Recommendation 7 – A new framework for telehealth
- Recommendation 8 – Reinvest in telehealth
- Recommendation 9 - Introduce a new framework of case conference items and allow access to all consultant specialists
- Recommendation 14 - Improve informed patient consent and shared decision-making practices
- Recommendation 15 –Case conference use of My Health Record
- Recommendation 16 – Incentivise adoption of My Health Record
- Recommendation 19 – Introducing a new AHP pathway

Members were presented with a summary of each of these recommendations and were asked to indicate for each the extent of their support, which could be 'agree', 'agree with caveats', 'don't know' or 'disagree'. They were also required to provide a written response indicating the reasons for their choice.

The internal consultation and survey process unearthed a wide diversity of views amongst RACP members in response to the Clinical Committee's recommendations.

The survey did not record whether the respondents were engaged in private practice although it was evident from the written responses provided that almost every respondent (who did not record 'don't know' as a response) had a familiarity with the relevant MBS items.

As stated above, this submission will present the views of members of the RACP as revealed through the results of the survey, together with additional written feedback received, including following from the circulation of the draft version of this submission to the wider Australian membership. **Appendix 1** presents relevant extracts from the written feedback that we received from this second stage of our internal consultation process to provide a flavour of the perspectives that we received from our different specialties.

We note that of the recommendations that were not specifically surveyed:

- Recommendations 3 and 4 relate to design and fee setting considerations for the proposed time tiered items and will be discussed where appropriate in our discussion of recommendations 1 and 5
- A separate section will provide some general observations and comments on the remaining recommendations that were not covered in the member survey. These are:
    - Recommendation 10 - Introduce case conference items for allied health professionals (AHPs) and nurse practitioners
    - Recommendations 11-13 relating to financial transparency
    - Recommendation 17 relating to additional measures to improve the functionality of My Health Record
    - Recommendation 18 to retain the current specialist to specialist referral validity period, and
    - Recommendation 6 is on appropriate access to paediatric complex plan items (we did receive specific written feedback on this recommendation from paediatricians which will be discussed in the section on complex plan items below).

2. Time tiered attendance items and complex plan items

Recommendation 1 proposes the introduction of time tiered attendance items to replace the current (untimed) standard attendance items for consultant physicians and specialists comprising initial attendances, subsequent attendances and complex management plan attendances. More than 66% of respondents agreed with the recommendation to replace initial and subsequent attendance items with time tiered attendance items though nearly half of those who agreed did so with caveats such as the need to take into account the amount of the rebates, the relativities between the rebates for the differing tiers, complexity as well as non-face to face activities (see **Table 1**).

Agree	35.3%
Agree with caveats	31.6%
Don't know	6.5%
Disagree	26.5%

n= 566; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 1: Responses to recommendation on time tiered attendance items

Recommendation 5 proposes that consultant physician, geriatric, addiction medicine, and sexual health medicine complex plan items would be removed and replaced by the introduction of time tiered attendance items – with complexity accounted for by higher rebates for the (assumed) longer

consultation times. This recommendation was supported by considerably more than were opposed (48.8% in support as compared to 34.7% opposed).

Agree	30.9%
Agree with caveats	17.9%
Don't know	16.6%
Disagree	34.7%

n= 531; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 2: Responses to recommendation on complex plan items

As recommendations 1 and 5 are related, they will be considered together in this section of our submission.

2.1 Benefits

Potential benefits of these two key recommendations as identified by its supporters can be grouped under the following sub-headings with further detail and examples provided underneath each:

A rebate structure which is more reflective of the broad patterns of consultant physician work can increase patient convenience (including reducing the need for repeated referrals and reducing the risk of out of pocket charges)

Respondents who supported these changes noted that the current structure of a higher paid initial attendance and lesser paid subsequent attendance items presupposes that subsequent consultations will require less work and time than initial consultations. While it is true that the initial consultation is likely to be more complex because it is the first time that the physician sees the patient and requires a significant investment of time and effort in learning about the patient and their medical history, this does not necessarily mean that subsequent consultations will always require less time or be less complex than initial consultations. The rebate structure needs to reflect the actual pattern of work undertaken so that patient rebates for time in subsequent consultations adequately cover costs of service provision (which then reduces the need to charge out of pocket costs).

For instance, in medical oncology, ongoing consultations can become increasingly complex and time consuming as the patient's disease progresses. Moreover, new issues may be discovered in follow up of patients with complex problems (e.g. in neurodevelopmental and behavioural paediatrics and geriatric medicine) which will require just as much time and effort if not more, than the initial attendance. Also, many complex patients including those paediatric patients with complex neurodevelopmental presentations may need more than one lengthy consultation to assess and formulate a management plan (not just one initial consultation, then reviews after that).

If the rebate amount provided for each timed tier of the face to face encounter is well aligned with the complexity and costs of providing the service, it is possible that this may support higher rates of future bulk-billing and consequent increased access by patients unable to afford significant out of pocket costs. Conversely a poorly aligned rebate structure across the different time tiers will likely have the opposite effect and result in higher out of pocket costs and reduced access for some patients.

The potential to introduce greater flexibility in provision of services and the increased convenience this provides to the patient was also seen by supporters of these recommendations as important to patients with complex needs given that the current complex plan item numbers are extremely limited - only one initial attendance and two subsequent attendances can be claimed every 12 months.

These current restrictions were seen as placing an additional burden on both the patient and the GP if the complex patient needs more frequent care.

Promoting shared decision-making and enhancing financial transparency

Supporters of these recommendations thought that if patients are sufficiently educated and well informed about the new system of time-based attendances, the time-based system could potentially enhance shared decision making between patients and clinicians; as well as improve their ability to provide informed financial consent. For instance, compared to the previous system where fees were set for non-timed attendances, under the proposed approach, the cost of the consultation would be more transparent to the patient. Theoretically if the patient thought it was worth spending additional time with the physician, they could request additional time and be able to know in advance how much more this would end up costing.

Opening access to patient rebates for a broader category of consultant physician services

Occupational and environmental medicine physicians predominantly welcomed the changes because it would provide them with common access to MBS items used by other consultant physicians at the same rates. Occupational and environmental physicians also noted that they typically needed long face to face assessment times in their initial attendances with patients and long time-based consultation items are therefore well aligned with these practice patterns. This relates to a broader point of importance to patient care, namely that the proposed changes open up opportunities for new kinds of consultant physicians to be more deeply involved in patient care.

2.2 Caveats

Based on the feedback received from respondents who agreed with the recommendations with caveats as well as feedback on particular nuances of clinical practices that cannot be properly captured by a pure time-based system we have identified the following sets of potential caveats or modifiers to time-based rebates that could be considered in the event that a time-based system was introduced:

- **A separate item for initial attendances should be retained**. This item should be non-time based and have a standard fee to account for the high upfront ‘expenditure’ of time for an initial attendance in laying the groundwork for future attendances. The requirement would be that this item would only be available for the initial attendances but that all subsequent attendances would then be based on the time tiered approach. We note that even among the respondents to our survey who supported the introduction of time tiered items there was support for retaining a differentiation between ‘initial’ and subsequent attendances.
- **A separate set of time tiered items should be created for attending to patients with complex multi-morbidities**. These items would be set at a higher payment per unit of time to account for the higher share of non-patient facing time that would be embedded into patient management. The patient cohort targeted by these items would be similar to those currently targeted by the complex plan items though there could be potential to develop some auditable indicator of complexity which incorporates the increased need for non-face to face time in such patients. For instance, this could take the form of a better specified initial attendances item for complex patients that might require a patient to have at least 2 active co-morbidities that the physician actively engages with. This set of time tiered items would be available to all specialties.
- For the reasons discussed in **Text Box 1** below, **the geriatric complex care items (141, 143, 145, 147) should be retained** as the services that are funded from patient rebates for

these items cannot be practically substituted for by longer patient facing time. Moreover, the patients who receive the services funded by rebates for these items generally cannot pay out of pocket charges and so the loss of these items would lead to the withdrawal of these services altogether. Some respondents have also suggested the creation of a category of 'extra complex' patients analogous to current item 141 but which would not be restricted to any particular specialty, and the creation of item numbers that would account for travel and site or home visits for such patients (such as currently available under item 145).

In addition to these caveats, many respondents questioned the premise that the complex plan items should be removed because of the cited statistic in the Committee report that 41 per cent of patients who receive a complex plan do not visit the referring practitioner within six months. It was pointed out that there could be many reasons for this, including successful treatment by the specialist or patients moving to another GP, and it required further investigation before being used as a reason for removing these items.

The RACP also received written feedback from paediatricians on recommendation 6 regarding access to paediatric complex plan items. The considerations discussed so far in favour of retaining specific items for complex patients would be applicable in the paediatric case and therefore all the feedback received was in favour of recommendation 6. One caveat or suggestion for improvement proposed was that to enhance the scope of this item number to cover all relevant factors, consideration could also be given to including descriptors or information on the combination of neurodevelopmental with other chronic conditions and how those co-morbid conditions interact in relation to the care needed. For example, it is not uncommon for a child to have both autism and diabetes (or indeed other complex endocrine disorders), which clearly interact with each other significantly and require input from both developmental paediatrics and paediatric diabetes specialists. Similarly, children with complex neurodevelopmental disorders at times have complex endocrine disorders (such as diabetes insipidus or pituitary insufficiency in a child with a brain malformation). These potential interactions should be covered in paediatric complex plan items. We also note that the Neurodevelopmental and Behavioural Society of Australasia (NBPSA) represents the majority of doctors working with the families of children with neurodevelopmental and behavioural conditions and is best placed to liaise direct with the Taskforce on a working definition for complexity and severity under recommendation 6.

Consultant physicians play an integral part in the healthcare of patients, particularly those with chronic multi-morbidities. Any proposals for reform will need to enhance consultant physician participation in the care and management of these patients. This underlines the emphasis we have placed on ensuring adequate complexity and non-face to face-based time is recognised.

At the same time, we acknowledge the limitations of enabling access to consultant physician care solely through the funding mechanism of MBS patient rebates.

In addition to MBS patient rebates, consideration should also be given to examining additional support mechanisms to enable patients to access high quality consultant physician care, particularly in supporting investment in complex information systems and essential non-patient facing activities. We note that blended and other incentive payment arrangements have played a role in supporting access to high quality care in other specialties.

2.3 Risks and weaknesses

The potential risks and weaknesses of these recommendations identified both by those who did not support the recommendations and those who supported the recommendations subject to caveats can be grouped under the sub-headings below with further detail and examples provided underneath each.

Risk of rewarding inefficiency and promoting 'clock watching'

Respondents who opposed the recommendations thought that the time-based system could lead to relatively more inexperienced or inefficient practitioners being over-rewarded compared to more experienced and efficient practitioners. Related to this, a time-based system may create incentives for both patients and/or doctors to 'clock watch' and place them potentially at odds, hence detracting from the shared decision making that should be the ideal of patient-doctor communication. For instance, patients may be reluctant to have an extended consultation – even if clinically necessary - if they fear having to pay a higher out of pocket cost (particularly if the fee set for patient rebates do not match service provision costs). An untimed initial attendance may make it easier for the patient to be unstressed about the amount of time the consultation requires, and for the clinician to collect the background and other information that will be essential for future follow up consultations.

There were concerns that while moving to a time-based system makes the cost of the consultation more transparent to the patient, the flip side for this is that the time spent may become the sole focus of the patient since that is the only indicator the patient can observe reliably (as the patient may be unable to assess the quality of the time spent). Patients may not realise that there is more time required for optimal care and management than just the face to face time and this may lead to conflict over the fees charged. This can subsequently lead to patient decisions which undervalue the benefits they get from seeing a predominantly or exclusively 'cognitive' specialty which provides little or no procedural services.

In light of these related concerns, it is important to ensure that the changed dynamics of the patient clinician relationship created by a time-based system does not detract from the main business of ensuring that high quality, high value care is provided. This leads on to the next concern expressed by respondents.

Complexities of implementing a time-based system and the adverse impacts this may have, particularly in in-patient settings, on future workforce

Respondents expressed concerns about the practicalities of introducing a time-based system in their daily practice and how this may detract from the focus on providing high quality care. Clinicians who worked in consulting rooms were concerned that under a time-based system, bookings may become more complex to coordinate as there is a need to build a contingency in for unexpected longer consultations. In addition to potentially leading to longer waiting times for patients if a patient requested additional time that was not accounted for, this could potentially add to the non-clinically relevant workload including administrative tasks further detracting from valuable clinical work. Related to this was a request for clarification on how time spent with a patient would be measured in the event of an audit e.g. whether this would be derived from the time allocated to the patient in an 'appointment book' or some other measure and if so, what documentation or other proof will be required to satisfy the requirements for each time tier period.

A large share of the concerns expressed regarding the practicalities of implementation came from clinicians working in an in-patient setting. One concern was about the difficulties of accounting for time in an in-patient setting where the consultant physician may be attending to multiple tasks (including providing phone-based advice) of very short duration and have consultations with multiple patients of very short duration (these can be as short as a minute providing advice). It was suggested that record keeping under a time-based system for such activities is unrealistic, if not unduly onerous. There were concerns that the difficulties of accounting for time in an in-patient setting could expose practitioners to higher audit risks and that this could then have a detrimental impact on access to high quality healthcare if it resulted in a significant share of the workforce withdrawing from in-patient services and only providing consultant physician services through consulting rooms. Many respondents wanted further clarification on how a time-based system could

work in an in-patient setting before they could express any commitment of support to the new approach.

Exposure to audit risk and resulting disincentives for clinically optimal care

There was a broader concern that a time-based system could expose some practitioners to higher audit risk due to significant differences in practitioner work profiles. Appropriate consultation times are unlikely to be uniform across all specialties. For instance, it is not uncommon for palliative care physicians to have consultations that take up to and over an hour. Specialities with longer than average consultation times which may be entirely appropriate may therefore be exposed to higher audit risk if these consultation times are seen as excessive. This may impact on high quality care if the increased audit risk induced these practitioners to shift to additional, shorter consultations to minimise such risks.

Potential under-valuation of non-patient facing time resulting in a higher risk of out of pocket charges and reduced in-patient services capacity

Survey respondents have emphasised that non-patient facing time is essential to consultant physicians, particularly those in the less procedural-based specialties (or cognitive specialties) as a significant amount of work is undertaken outside of a consultation such as reviewing a complex patient's records and synthesising information from multiple sources as well as preparation time, chasing up other test results and preparing request forms and scripts. For instance, diabetes specialists noted that increased use of diabetes technology (reviewing and interpreting complex glucometric and insulin delivery data downloaded from (continuous) glucose meters and insulin delivery devices) significantly increases patient management time outside of face to face time. They argued that these tasks are at least as complex and time consuming as that required for interpreting ECGs (an activity which has its own MBS item number).

While recommendation 4 partly addresses the non-patient facing time issue by specifying that in setting MBS rebates, there should be recognition of the significant non-patient-facing time spent on each attendance, this may not appropriately address the disparity in the share of total patient management time that is spent in non-patient facing time between the cognitive and more procedural based specialties. For instance, assume that fees for each attendance time tier are set taking into account the average non-patient facing time associated with such attendances across all specialties as per recommendation 4. Then this is likely to undercompensate the 'cognitive' specialties for their non-patient facing time. Assume alternatively that non-patient facing time were set according to the average patient facing time of the cognitive specialties. While this might lead to an outcome that properly compensates the cognitive specialties, it would also now overcompensate the procedural specialties who claim from the common schedules. The resulting over or under compensation could result in distorted future workforce decisions that do not appropriately reflect community demands for procedural versus non-procedural services.

The main **immediate** risk from not adequately recognising non-patient facing costs in the setting of patient rebates is that this will mean that for some specialties, particularly those which require a high share of non-patient facing time, patient rebates will not fully cover service provision costs even if rebates increase with the amount of patient facing time. This will result in an increased risk that practitioners need to charge above patient rebate levels to recover their costs, increasing the exposure of patients to out of pocket charges.

Some respondents also reported that in the in-patient setting, many daily attendances are relatively quick compared to outpatient consultations but require much more non-face to face time. Therefore, if patient rebates are set undervaluing this time, this may induce some consultant physicians to shift to wholly outpatient attendances.

Insufficiently accounting for patient complexity in the setting of patient rebates, resulting in suboptimal care for complex patients and/or their increased exposure to the risk of out of pocket charges

Adding to the above complication, non-patient facing time as a share of the total working time spent by consultant physicians is also likely to be higher for managing patients with chronic and complex disease (who currently qualify for rebates under the existing complex plan items). Some examples of non-patient facing time from geriatric medicine are highlighted in **Text Box 1** below though paediatric medicine is also another domain where patient complexity is the rule rather than the exception.

Increasing patient rebates with longer patient facing time (as implied by the descriptors for the proposed time-based system) would therefore be insufficient to account for the costs of managing more complex patients if corresponding increases in non-patient facing time are not sufficiently accounted for. Yet a significant assumption behind Recommendation 5 is that seeing more complex patients can simply be accounted for by billing for longer patient facing time. Another consideration is that factors such as slow patient mobility, a poorly speaking patient, or minimal information provided by a referring practitioner might lead to a longer consult but not necessarily a more complex one. By contrast a very ill patient requiring complex decision making or referral to hospital could end up being a short face to face consultation.

As noted multiple times throughout this submission, insufficiently accounting for the costs of service provision in patient rebates (such as the costs of non-patient facing time) may result in a higher risk of patient exposure to out of pocket charges. A further unintended consequence could be a longer-term decline in the number of practitioners equipped with the skills, knowledge and expertise for managing complex patients.

Geriatric medicine physicians in particular have expressed significant concern about the loss of their complex care items - many of which they regard as not easily substitutable for time as these cover site and home visits including to residential aged care facilities (RACFs) as well as providing for a holistic review service, namely the Comprehensive Geriatric Assessment (CGA). **Text Box 1** expands on these points.

In addition, the vast majority of RACF patients seen by geriatric medicine physicians who receive rebates for these item numbers cannot afford to pay out of pocket costs for specialist care. Therefore, the loss of these complex care items would potentially result in a reduction in provision of these services altogether, including home and RACF visits, with a correspondingly reduced access to geriatric care in the community (rather than 'just' an increase in out of pocket costs).

It was also noted that the complex items include a rigorous set of item descriptors compared to the proposed time-based items. Loss of these items could potentially simplify private work undertaken by geriatricians but would mean a reduction in the high quality benchmark currently set by the CGA.

Text Box 1: The Comprehensive Geriatric Assessment: An example of why non-patient facing time managing complex patients cannot be easily substituted for by longer timed attendances

The CGA is a multi-dimensional process used to quantify an older person's medical, psychosocial and functional capabilities and at the same time an intervention used to manage frail or vulnerable older people. It includes diagnosis, problem-identification, goal setting, and formulation of a comprehensive management plan for treatment, rehabilitation, support and long-term follow-up. Provision of a CGA is a core skill of Geriatric Medicine consultant physicians, and the specialty training encompasses diagnosis and management in aspects of older person's health such as multi-morbidity, polypharmacy, dementia and cognitive impairment, and the related syndromes and effects of sarcopenia, frailty and functional impairment.

The CGA is the most comprehensively researched model for healthcare delivery to frail older people, and has been shown through multiple research studies and meta analyses to deliver measurable health outcomes via optimising physical and cognitive function, living location, reducing hospital admissions, and reducing mortality.[1] Geriatricians emphasised that the CGA is time consuming, not just in terms of patient face to face time but in terms of the amount of follow up required with community organisations and family. For these various reasons, the item numbers applicable to the CGA are regarded in many respects as quite unique and cannot be duplicated simply by billing more patient facing time.

[1] Ellis G, Gardner M, Tsiachristas A, et al. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD006211

Lack of health economic modelling to capture unintended consequences of rebate design

The lack of health economic modelling undertaken to assess the effect of time tiering on the viability of private practice and the potential shifts it may induce between activity in community, private and the hospital system has been a concern identified by some respondents. Such modelling is essential for capturing some significant differences between different kinds of specialties as well as between different clinical settings – for instance, the higher overhead costs faced by physicians in private practice who have their own consulting rooms and staff expenses compared to those working in in-patient settings.

While we acknowledge that the specific quantum of rebates is outside the scope of the Clinical Committee, some health economic modelling could have been undertaken based on the assumption of parity between current funding arrangements and the proposed new structure (for instance the proposed time-based consultations for over 5 minutes could be modelled to be set at an MBS rebate level equal to the current item 110 amount, and those approaching 45 minutes modelled to be set at the level of the current item 132 amount) to ensure that the changes do not result in unintended consequences. One example of rebate design that may not reflect clinical practice but could have been picked up through some form of modelling is that the time-tiered consultation of 5 minutes or under for a face to face consultation may be unrealistic, as there is little prospect of a meaningful face to face consultation of under 5 minutes; while the time-tiered consultation of 5-20 minutes may be too broad as there are very clear differences between a 6 minute consultation and a 20 minute consultation.

3. Recommendation on new attendance items for acute, urgent and unplanned attendances

Recommendation 2 is for the introduction of new attendance items for acute, urgent and unplanned attendances which would be set at higher rates than standard time-based attendance items.

There was 61% agreement with this recommendation compared with 16.3% disagreement (see **Table 3**).

Agree	61%
Agree with caveats	12.4%
Don’t know	10.4%
Disagree	16.3%

n= 566; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 3: Responses to recommendation on new items to reimburse acute, urgent, and unplanned attendances at a higher rate

3.1 Benefits

Key reasons for supporting the recommendation were:

- Acute, urgent and unplanned attendances tended to disrupt planned attendances and other clinical activities, requiring the physician to then ‘catch up’ with appointments for the rest of the day. These activities also required more mental effort relative to routine follow ups as these are appointments which are unplanned and require the physician to process information and make diagnosis quickly. It was therefore appropriate to provide additional incentivisation for these activities to ensure adequate levels of specialist and consultant physician workforce capacity could be allocated towards these areas which in some cases could be matters of life and death.
- In general, these categories may often require more work that is not face to face e.g. communication with others (which as discussed previously, means a loading may be justified as service provision costs cannot be fully recovered through time-based rebates). At the same time, better care for patients of this cohort could also reduce hospital admissions and help patients remain in the community for longer.

3.2 Risks, weaknesses and caveats

The key concerns identified with this recommendation was that it is inconsistent if time-based consultations were to be introduced to then have new items which were also potentially time based being weighted more. For instance, some respondents wondered why, if a time-based system were applicable, the additional patient facing time that may be required for these kinds of attendances could not simply be covered by charging against a longer time tier.

Thus, one key caveat expressed among those who otherwise supported the recommendation was that these activities should be defined carefully to avoid unintended consequences arising from changed incentives. There were also queries about why these items could not be claimed in specialists’ consulting rooms. It was suggested that insofar as this exclusion was to prevent overuse, this could be addressed by issuing clear guidelines about when these items can be

claimed in consulting rooms; and that it was worth expanding the coverage to consulting rooms, because an appropriate and timely assessment by a physician often leads to more targeted investigation, avoids unnecessary hospitalisation and leads to earlier diagnosis.

4. Recommendations on telehealth loadings

Recommendation 7 proposes incrementally reducing the derived fee for the nine telehealth loading items to zero, with annual analysis of its effects to identify potential unintended consequences, while recommendation 8 proposes all savings from removing the telehealth loading be reinvested towards non-MBS mechanisms for encouraging telehealth use, primarily in the form of education and awareness raising campaigns.

There was no clear majority support or opposition to these recommendations (see **Table 4**). However, there was slightly greater opposition to (29.8%) than support for (25.3%) the recommendations, with almost half the respondents stating that they did not know.

Agree	19.4%
Agree with caveats	5.8%
Don't know	45%
Disagree	29.8%

n= 531; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 4: Responses to recommendation on telehealth

After removing the significant number of 'don't knows', the share of respondents who disagreed was 54.1%.

4.1 Benefits

Those who supported the recommendations generally did so on the basis that existing loadings may lead to the use of telehealth where it is not fully justified or could create scope for 'gaming', while others thought that it was inevitable that the loadings be removed as the technology would gradually become easier and more widespread anyway. These considerations imply that there are no more additional benefits to be gained from the implicit subsidy to further expand the reach of specialist telehealth services, and also that the existing coverage of specialist telehealth can be maintained absent this implicit subsidy. This judgement was questioned by those respondents who opposed the telehealth recommendations (see the next sub-heading).

4.2 Risks and weaknesses

The potential risk and weaknesses of these recommendations identified by respondents are documented below.

Withdrawal of telehealth loadings will lead to withdrawal of telehealth services altogether

Most of the respondents who opposed the telehealth recommendations cited two main factors which meant that the withdrawal of loadings would lead to the withdrawal of the provision of telehealth services altogether (rather than practitioners attempting to recover these costs through out of pocket charges):

- Contrary to the Committee's implied position there are higher, not lower marginal costs associated with setting up telehealth consultations compared to face to face consultations (for the numerous reasons stated below)
- Typically, practitioners would not bill out of pocket charges for the kinds of patients who use telehealth, particularly given that these patients tend to live in remote areas.

The above considerations mean that if patient rebates for these consultations no longer cover the cost of telehealth consultations, practitioners would have to stop providing these services altogether (the alternative being for practitioners to bear these additional costs or cross subsidise them from other parts of their practice). Among the reasons for the higher marginal costs associated with setting up telehealth consultations are the following:

- Equipment and staff including administrative support may be needed at the patient 'end' of the line if some kind of medical assessment is needed during the consultation. The assistant may be required to undertake the assessments at the patient's end and this may even require infrastructure at both sites for a consultation (equipment, secretarial, clinical assistance/nurses). Moreover, telehealth services for some patients (e.g. children with complex conditions) may take longer than an in-person consultation due to potential difficulties with managing user-end technology, behavioural issues, hearing impairment, and possibly cognitive impairment.
- The administration of telehealth also requires new skills including a broad knowledge of cybersecurity requirements as well as the acquisition of new skills in risk management and assessment. Whether this is undertaken by the clinicians or delegated to another employee, additional costs must be incurred.
- Adding to these issues, it is also logistically more complex to schedule a telehealth consultation than a face to face one. In terms of timing, there is little flexibility allowed for the clinician given the importance of scheduling an exact time and little scope for time being wasted due to the appointment schedule and connection issues.

It is unclear that non-MBS mechanisms for supporting telehealth which are being proposed by the Committee (which essentially amount to greater patient and clinician awareness of these options) will be a sufficient substitute for these loadings if the key issues are financial and logistical barriers to establishing telehealth consultations.

Access to specialist services in rural, regional and remote areas (including Indigenous health services) are therefore likely to suffer as a result of reduction and ultimately removal of loadings, particularly for those services such as rheumatology services which are less likely to be provided in public hospital clinics. It was noted that in rural, regional and remote areas the facilitation of telehealth services because of current loadings has supplemented monthly fly in fly out services to rural areas leading to improved quality of care by enabling rapid feedback of test results and initiation of appropriate management. It also provides valuable education for rural GPs who often participate in specialist telehealth consultations.

There is scope for additional expansion of telehealth services and the benefits it brings, and this could be prematurely halted by the withdrawal of telehealth loadings

Respondents have also argued that contrary to the claims of the Committee:

(i) There is still significant scope for the further expansion of telehealth and its use is far from any 'saturation point'

(ii) There are benefits from the use of telehealth services which go beyond the individual patient or practitioner and their treatment outcomes, which may justify an implicit subsidy for telehealth (independently of whether these services involve higher marginal costs of provision).

These claims have significant empirical support. Not only are such tele-consultations effective in providing good patient management to people living remotely, but there are arguments that they should be made available to patients who do not live remotely which implies that telehealth, is, if anything, still being significantly under-used in Australia. For instance, recent research suggests that increased use of telehealth can lead to reductions in MBS and PBS expenditures and reductions in hospitalisation. [1] This constitutes a positive externality (that goes beyond the individual patient being treated using telehealth) because it frees up hospital capacity and reduces unnecessary pharmaceutical use.

An additional factor to consider is patient waiting time – the costs associated with travel and waiting times tends to be neglected but a recent analysis by the Productivity Commission indicates that the use of telehealth for just 10 per cent of consultations would save over $300 million annually in travel and waiting times which is why the Commission actually advocate lifting current distance restrictions on the claiming of telehealth benefits. In addition to these are the obvious benefits in reducing carbon emissions from using telehealth where appropriate. Some of these carbon emission reductions will arise from the reduction in travel projected below. Some practitioners noted that there were some services which could be more efficiently delivered through telehealth because they did not require face to face consultations. An example provided was stabilisation of insulin which involves scheduling, patient reminders, arranging and checking prior pathology, and remote downloading of meters and insulin pumps which the specialist could work through with the patient remotely.

Thus, rather than disinvesting in telehealth it should form part of a broader national digital health strategy. Related to the above, some respondents recommended dropping the restriction on access to telehealth eligible areas because some patients need to spend a long time travelling to see the appropriate specialist even if they are in metropolitan areas, while others have restricted mobility such that a telehealth consultation may be entirely appropriate for certain specialist reviews.

5. Recommendations on simplification of case conferencing items

Recommendation 9 proposes a new framework of case conference items which would be accessible to all consultant specialists.

There was more than 67% agreement with these recommendations compared with less than 5% disagreement (see **Table 5**).

Agree	53.9%
Agree with caveats	13.9%
Don’t know	27.9%
Disagree	4.4.%

n= 517; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 5: Responses to recommendation on case conferencing items

5.1 Benefits – Administrative simplification and greater flexibility

Potential benefits of these two key recommendations as identified by its supporters were:

[1] Celler et al. 2016, Home Monitoring of Chronic Illness for Aged Care , May, Australian e-Health Research Centre, CSIRO.

- It would simplify and streamline the current structure which is overly complex. This will ultimately benefit patient care, including informed patient consent, as it makes it easier for both practitioners and patients to navigate the MBS system, while freeing up practitioners to focus on clinically necessary activities.
- The proposed new item numbers also recognise case conferences which were not previously covered and thus allows more flexibility in claiming rebates, enhancing access to a broader range of clinically necessary case conferencing which ultimately benefit patient outcomes. Specific examples cited by respondents are:
    - Recognition of discharge planning conferences.
    - Current case conference items mandate that the patient needs to be discussed for at least 15 minutes. The proposed new item numbers introduce a time tier of less than 15 minutes which recognises that even though a case is complex and there are multidisciplinary team members involved, a case conference can be concluded in under 15 minutes.

5.2 Risks, weaknesses and caveats

Concerns and caveats identified both by those who agreed with caveats and those who disagreed with the recommendation tended to fall into two broader categories.

- The new items introduce additional and potentially onerous new requirements which could limit their uptake and thereby limit rather than facilitate some clinically valuable case conferences:
    - Some respondents argued that it was not realistic to mandate the required number of participants. Suggestions for amendment include reducing this to two other allied health disciplines or three other people (who can be of the same discipline). Others have suggested there should be no restriction on the number and type of medical practitioner or allied health professionals who can be involved.
    - The requirement for GP attendance at all case conferences was also seen as potentially limiting. At times it may be difficult to schedule case conferences within the hospital while also fitting in GPs' booking times and systems. It was suggested that while the involvement of the GP or their delegate is highly desirable, a better approach may be to mandate communication to the GP of all conference outcomes. In the case of Aboriginal medical services where GPs may not have adequate time to participate, a practice nurse or other allied health professional such as a diabetes educator can adequately fill that role.
    - Some paediatrician respondents recommended that there should be provision for a case conference item which excludes the patient and their family as this would be appropriate for paediatric patients with a neurodevelopmental disorder.
    - Requiring mandatory patient invitation (even where patient attendance is not required) is not practical and may inconvenience the patient who may feel pressured to attend because they think it is an appointment for them when it is actually the team planning their care. This is more so where the patient is elderly, or has limited access to mobile phones or transportation options.
    - One respondent suggested that case conferencing items should also recognise those cases where consultant physicians co-consult with GPs without other health professionals being involved as there are clinically valuable opportunities for these smaller co-consultations – for instance, there are benefits to GP capacity in terms of increased knowledge and skills in managing specific conditions and benefits to

consultant physician capacity in terms of learning more about the patient's health and better backgrounding from the GP.

- Some respondents thought that the requirement to ‘Organise' and 'Participate' in case conference could be better defined and item descriptors should be subject to review to reduce incentives to ‘game’ the system.

6. Recommendation on improving informed patient consent and shared decision making

Recommendation 14 covers a range of proposals to improve informed patient consent and shared decision making including the proposal that when multiple treatment options are available, standard attendance item descriptors should include discussion of treatment options, consideration and discussion of referrals to other health professionals and written documentation on treatment options to the patient and/or carer.

There was more than 72% agreement with these recommendations compared with 17.8% disagreement (see **Table 6**).

Agree	55.1%
Agree with caveats	17.8%
Don’t know	9.4%
Disagree	17.8%

n= 523; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 6: Responses to recommendation on multiple treatment options

6.1 Benefits – enshrining what should already be good clinical practice

The majority of respondents supported this recommendation as they thought it should already be good and standard medical practice. One key caveat that was identified among respondents who otherwise agreed was that the treatments to be discussed should be optimal and evidence based as it did not make sense to go through suboptimal/unproven treatments with every patient.

6.2 Risks and weaknesses – potential for requirements in descriptors to become onerous and detract from high value care

A key risk identified by those against the recommendation was that while the kinds of discussions outlined in the recommendation were good practice, formalising this into item descriptors would pressure doctors into discussing every option (no matter how inappropriate) for the patients and some disagreed with the proposed requirement that there be written documentation of treatment options, which was considered impractical and burdensome and not necessary in all cases where there were multiple treatment options e.g. where the first-best treatment option was clear and grounded in evidence.

Caution was also expressed by some respondents that account needed to be taken of the increased time requirements for the specialist involved, some of which would be non-patient facing (e.g. in writing and researching the documentation of treatment options).

Another concern was that the requirement to provide written information to patients about treatment options would not be relevant in those cognitive specialties where much effort and time is spent just trying to establish the diagnosis and is more applicable to proceduralists. It was therefore proposed that this requirement be limited to written information about procedures, rather than covering every possible investigation as part of treatment. Also, it would be important to understand how this recommendation would be implemented and 'attached' as a requirement to the time tiered item descriptors to ensure that physicians are not disadvantaged in what they can claim for patients if despite complexity there are not many treatment options available e.g. a complex food allergic patient where the only current option for management is avoidance of multiple foods.

7. Recommendations on My Health Record

There are two sets of recommendations relating to My Health Record that were covered in our survey. These are discussed in separate subsections below.

7.1 Requirement to upload case conferences to My Health Record

Recommendation 15 is that outcomes of case conferences be uploaded to My Health Record. Specialists organising the conference would be responsible for the uploading of treatment planning case conference outcomes while GPs organising the conference would be responsible for the uploading of community and discharge case conference outcomes.

There was no clear majority support or opposition to these recommendations (see **Table 7**). However, there was greater support for (44.1%) than opposition to (35.6%) the recommendations.

Agree	25%
Agree with caveats	19.1%
Don't know	20.3%
Disagree	35.6.%

n= 517; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 7: Responses to recommendation on uploading case conferences to My Health Record

After removing the one fifth of respondents who answered 'don't know', the share of respondents who agreed was 55.3%.

Benefits – Promoting better communication between practitioners can enhance patient care

Respondents who supported this recommendation pointed to the importance of some form of communication to GPs and other healthcare practitioner regarding discussion outcomes and the importance of ensuring that My Health record is properly populated with case conference outcomes, making them widely available to enhance patient care. However, this support is subject to some important caveats and concerns – in particular that the process for uploading documentation be made simpler and security on My Health Record should be improved.

Risks and weaknesses – Promoting use of a system which some practitioners regard as still lacking sufficient coverage, functionality and utility

Concerns about usability and security of My Health Record were paramount among respondents who were against this recommendation and was the main reason for their opposition. Another concern was that this recommendation would foster inequity in the availability of electronic medical

data as either a significant share of the population has opted out of My Health Record and/or many physicians are themselves not registered for My Health Record. This would mean that either those who had opted out or who had physicians who had opted out would be deprived of the improvements that might come from case conference uploads. Moreover, where highly sensitive material is discussed, it may not be appropriate to upload the case conference for all to see.

Concerns were also expressed regarding the capacity for clinicians to participate in My Health Record when they work out of multiple facilities as the registration is location specific. Some respondents also identified the risk that making case conferences too burdensome by imposing this additional requirement would discourage case conferencing.

7.2 Incentive payments for uploads to My Health Record

Recommendation 16 is to introduce in the MBS a single incentive payment to consultant specialists upon their adoption of My Health Record, triggered by achieving a volume of uploads that is proportional to the number of attendances that the provider performs. There was no clear majority support or opposition to these recommendations (see **Table 8**). However, there was greater opposition to (44.1%) than support for (36.1%) for the recommendations. After removing the one fifth of respondents who answered ‘don’t know’, the share of respondents who disagreed was 54.9%.

Agree	22.4%
Agree with caveats	13.7%
Don’t know	19.7%
Disagree	44.1.%

n= 517; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 8: Responses to recommendation on uploading case conferences to My Health Record

Benefits – Recognition of time and effort involved in uploading case conferences to My Health Record

Respondents who supported this recommendation stated this was justified for the recognition of the additional (non-patient facing) time involved in uploading case conferences to My Health Record, not to mention the costs of connecting to and using the system. However, among these respondents who supported incentive payments, there were concerns and caveats about the specific form that these incentive payments would take. In particular, there was concern that requiring a minimum upload would incentivise the population of the patient record with irrelevant information reducing the utility of the system. Among supporters with caveats, one alternative approach proposed by some respondents, given the variable uptake of My Health Record by patients and the need to compensate for the extra administrative burden involved was to introduce a small incentive, per upload, in a continuous, ongoing fashion without the minimum threshold requirement.

Risks and weaknesses – Incentivising use of a system which some practitioners regard as still lacking sufficient coverage, functionality and utility, and conflict of interest considerations

The main reasons identified by respondents for opposition to the recommendation were:

- There were too many remaining issues associated with My Health Record relating to its coverage, functionality and utility that still needed to be resolved so it would be premature to incentivise use of the system until these were properly addressed. Respondents with these

concerns cited existing privacy and security concerns associated with My Health Record and the distrust among a significant share of the community and physicians themselves in the value and effectiveness of participation in My Health Record. Other respondents expressed the concern that the software used in a lot of specialist clinics is not yet compatible with My Health Record and a simple upload-based incentive would not address that. It was also noted that it may not be possible in some cases for an individual specialist to link to or access their own patients' MHRs, except through invitation from a larger institution such as a hospital where the patient was previously treated. The conclusion of these respondents was therefore that the process of access for MHR for specialists is cumbersome and needs to be improved before payments are introduced for using it.

- Concern that the creation of an MBS item for this activity would create a financial conflict of interest between the physician and the patient as the physician would have an incentive to opt into My Health Record in cases where their patients were against participation. Even if the conflict of interest was merely a perceived conflict of interest this might add distrust into the physician patient relationship.

8. Recommendation on direct referrals to Allied Health Professionals and nurse practitioners

Recommendation 19 proposed the introduction of a new Allied Health Pathway. There was more than 55% agreement with these recommendations compared with 22.5% disagreement (see **Table 9**). After removing the one fifth of respondents who answered 'don't know', the share of respondents who agreed was even higher, at 71%.

Agree	42%
Agree with caveats	13.1%
Don't know	22.5%
Disagree	22.5%

n= 512; figures have been rounded to nearest decimal place and therefore may not add up to 100%

Table 9: Responses to recommendation on direct referrals to Allied Health

The key benefits of this recommendation as identified by its supporters were in terms of facilitating better team care and reducing costs and inconvenience for patients (who will no longer need to return to GPs to get a referral).

8.1 Benefits

Facilitating team care

Specialists who deal with patients with chronic complex comorbidities cited the benefits of being able to refer directly to allied health professionals to support the most clinically appropriate treatment. As allied health professionals typically have a long-term relationship with their patients that is comparable to the relationship that patients have with GPs, this pathway was seen as a means to enhance opportunities for direct collaboration between allied health and consultant physicians and specialists. Examples of specialty specific reasons for supporting more direct referrals include the following:

- Physicians in allergy practice want to be able to directly refer patients to specialist allergy dieticians.

- Endocrinologists and other diabetes specialists would like to directly refer patients to a diabetes educator or dietician.
- Gastroenterologists would like to directly refer patients to dietitians, psychologists, physiotherapists and speech pathologists.
- Neurodevelopmental and behavioural paediatricians would like to be able to refer children for audiology assessment without the family needing to return to their general practitioner for a referral. They would also be able to refer to other allied health practitioners such as physiotherapists, occupational therapists, speech pathologists and dieticians.
- As a suggestion for improvement, one respondent noted that genetic counsellors should be included as allied health practitioners that have access to this pathway as best clinical practice for a patient requiring genetic testing would be to see a clinical geneticist and a genetic counsellor.

This recommendation was also seen more broadly as a means of fostering multidisciplinary team-based care. For instance, by enabling endocrinologists to refer patients back to allied health professionals in a primary health care setting, this would greatly aid transitioning diabetes patients from specialist care back to primary care.

Reducing patient cost and inconvenience

Respondents who supported the recommendation also noted that the direct referral pathway would reduce the cost and inconvenience to the patient who would no longer be required to return to the GP to obtain a referral to appropriate care prescribed by the specialist. Nonetheless some who saw benefits in this streamlined approach cautioned that the patient's GP should still be kept informed of the direct referral and that their engagement was still crucial to ensure there was genuine team care. However, it was thought that this could be achieved by appropriate communication without requiring the patient to get the referral from the GP.

8.2 Risks and weaknesses – reduced GP engagement and increased risk of unnecessary referrals

The key risks and weaknesses of the recommendation identified by respondents who were opposed to it were that:

- By bypassing GP referrals, there was a risk that this pathway, rather than facilitating team care could cause leave the GP out of the loop. Respondents who expressed this concern thought that GP should remain the 'gatekeepers' of the health system and that this pathway could undermine that role.
- Related to above, if GPs were to be bypassed through the new direct pathway process, this could lead to more unnecessary referrals, at least unless there were strict protocols in place to ensure that the referrals were promptly communicated to GPs. An alternative approach identified was to restrict access to the direct pathway to special cases (e.g. where a patient is assessed as meeting a level of complexity).

9 Other recommendations of the Committee

9.1 Recommendation to retain the current specialist to specialist referral validity period

The MBS Review Principles and Rules Committee had previously considered the current specialist to specialist referral validity period of three months and whether it should be extended and had recommended keeping the validity period to three months. The reason cited by the Principles and Rules Committee was that the current validity period struck a balance between providing for flexibility in referrals while still retaining GP oversight. Recommendation 18 of the Specialist and Consultant Physician Consultation Clinical Committee is to reaffirm the recommendation of the Principles and Rules Committee though the Clinical Committee did consider the case for extending the validity period to six months.

The RACP welcomes the opportunity to draw the Clinical Committee's attention to the arguments that we made in our previous submission to the Principles and Rules Committee:

- Although the concept of the 3-month limit on specialist to specialist referrals makes sense in many settings, the issue is much broader than is recognised by the current validity period.
- Firstly, many inpatient referrals from one specialist/consultant to another are not accompanied by a written referral. For example, a surgeon operating on a patient with diabetes might call an endocrinologist asking them to manage the patient's glycaemic control whilst they are in hospital. Although this might be noted on the patient's record, a written referral may not be provided under such circumstances. The question then becomes whether if audited, the claim by the endocrinologist would be accepted for the genuine services provided. Therefore, consideration is needed to ensure that practitioners providing necessary inpatient care to patients under another specialist/consultant physician are not penalised.
- Secondly, the specialist to specialist referral framework should make allowance for cases of private patients in public hospitals following attendance at the Emergency Department (ED) as current regulations on referrals result in the Resident Medical Officer (RMO) having to go through a variety of processes for many such ED patients to enable them to allocate the referral as being from their consultant as required.
- There is also the issue that many patients being discharged, either from ED or following an acute admission, do not have an identifiable GP. Changes are needed to simplify and streamline the referral rules in these instances, and consideration given to allowing a post-referral time period of up to 12 months. This would save unnecessary GP attendances and time spent on referring to GPs without breaking the principles of the centrality of GP care.

9.2 Recommendations on promoting greater financial transparency

Recommendations 11-13 bundle together a number of recommendations which do not directly relate to the design or specification of MBS items but relate to recommended actions by other government bodies or agencies:

- Recommendation 11 is that the Principles and Rules Committee examine the issue of informed financial consent for out-of-pocket fees charged with case conference items.
- Recommendation 12 is to establish a national minimum data set to inform evidence-based clinical practice and inform patient choice.
- Recommendation 13 is that:
    - MBS cost data, including data on out-of-pocket fees, is shared at an institutional and individual provider level

- consultant specialist risk-weighted outcome data discussed in Recommendation 10 is shared at an institutional and individual provider level
- cost and outcome data are shared with the patient through their GP at the time of referral
- the presentation of cost and outcome data should be co-designed with consumers and include a clear explanation of the data and its limitations.

On recommendation 11, the RACP has consistently advocated that there should be appropriate policies and systems in place to ensure that patient contributions do not create inequities in access to care and lead to vulnerable people being further disadvantaged and deprived of services that should be available to all Australians based on their need and not on their ability to pay. Measures to improve transparency constitute a 'low hanging fruit' solution to the equity problems generated by high out-of-pocket expenses, as it is intrinsically desirable that patients have better access to information on the costs they are likely to face when seeking medical treatment. We therefore welcome the insights that may be brought to bear on it by the proposed inquiry.

However, regarding the framework on a national minimum data set proposed by recommendations 12 and 13, the RACP would like to see more detail on the proposed measures of consultant specialist risk weighted outcome data before we can comment further. For instance, we note that while it is relatively more straightforward for surgeons and other more procedural based medical practitioners to provide morbidity and outcome data using various measures, consultant specialists and physicians encompass a wide range of practices with a strong element of 'cognitive service' provision. Any reporting of information relating to specialist fees would also need to take into account the consideration that non-procedural physicians spend a lot of time with complex patients including more non-face to face time while generating no income from procedures. It is also important to ensure that the reporting of performance information does not discourage some practitioners from treating complex patients because this may jeopardise their ratings. Any measurement and collection of data, particularly on outcomes for groups covered by the RACP will need careful consideration and input from relevant specialty groups, with appropriate customisation for the specialty being considered.

9.3 Recommendation to introduce case conference items for allied health professionals (AHPs) and nurse practitioners

In the case of AHPs, this recommendation is only meant to apply to those who are eligible to access AHP items under Group M3 of the MBS – this covers Aboriginal and Torres Strait Islander health practitioners, Aboriginal health workers, audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, mental health nurses, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, social workers, and speech pathologists. The recommendation is in recognition of the central role that AHPs and nurse practitioners play in patient care, particularly in a community setting. It is proposed that speciality nursing staff be added to the "allied health professionals" to which these items apply. For example, specialist endocrine nursing staff have a key role in ensuring education around disease management and safety – this is particularly important for families who live in regional or remote communities.

The RACP has consistently advocated for policies and frameworks to facilitate better communication and interaction between practitioners across health sectors. This is particularly important in the case of care for chronic conditions which cannot be confined to one part of the health sector – these increasingly prevalent conditions often require care at various times at each of the primary, secondary and tertiary sectors. Allied Health and nurse practitioners have key roles to play in such care and the RACP therefore supports this recommendation.

9.4 Recommendation to improve the functionality of My Health Record

Recommendation 17 sets out a series of proposed actions which would primarily be driven by other government bodies and health sector stakeholders to improve the functionality of My Health Record and educate consultant specialists on the benefits of its use including broadening training for health care providers to include education about using the My Health Record system clinically and working with academic institutions to embed digital health competencies into undergraduate and postgraduate training and CPD programmes.

The RACP has been a consistent advocate for the benefits that digital health can bring to the healthcare sector. We expect that if My Health Record can facilitate greater and more effective use of digital health that this would yield patient benefits due to:

- reduced frequencies of medication error and adverse drug events;
- reduced errors due to illegible handwriting, faxes and lost paper records;
- better management of patients with complex illnesses who need to see multiple health care providers by facilitating continuity of care;
- better targeted treatment of renal and other chronic conditions in remote Indigenous communities; and
- reductions in duplication and overutilization of medical imaging and pathology requests.

We therefore support the considerations of measures to improve the functionality of My Health Record including the ones covered in this recommendation and look forward for the opportunity to provide input into the processes suggested in this recommendation.