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MBS Review Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC) report

AMA submission to the MBS Review Taskforce

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Introduction

The AMA appreciates the opportunity to provide feedback on the Draft MBS Review Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC) report. The report was released for consultation on 5 February 2019, with an initial closing date of 17 May, which was extended to 28 June 2019, in response to advice from the AMA about the lack of awareness amongst the profession regarding the report and its significant proposed reforms.

Although the AMA is thankful that the MBS Review Taskforce extended the submission timeframe, more could have been done to better communicate the proposed changes to specialist consultants and their representative organisations. The initial information session held on 13 March 2019 was organised with short notice and did not provide adequate lead time, nor provide useful widespread communication regarding the proposed changes. As noted in the SCPCCC report, the specialist consultant attendance section of the MBS is structurally complex and the proposed recommendations are also difficult to unpack and digest.

In preparing its response, the AMA spent a significant amount of time raising awareness amongst the profession, who were largely unaware of the report, and producing simplified summaries of the report recommendations for busy clinicians and peak bodies to understand and enable meaningful responses. This included a letter sent from the AMA President to medical Colleges, Associations and Societies and a letter from the President published in the AMA's Australian Medicine magazine, as well as direct emails to members.

The MBS Review Taskforce did previously provide regular digestible communication to the profession and public via quarterly newsletters. However, the newsletters have not been published since June 2017 and the profession are largely left in the dark and are now required to spend significant amount of time chasing relevant information and understanding the complex

and detailed Clinical Committee reports, instead of spending this limited time consulting with its members and counterpart organisations.

Despite these challenges, the AMA worked very hard and managed to consult widely with its members via an online survey, discussions with AMA Councillors and relevant AMA Committees and Councils, and direct member feedback via the AMA's state and territory offices, and the following organisations:

- The Australian Association of Consultant Physicians (AACP);
- The Royal Australasian College of Physicians (RACP);
- The Royal Australian & New Zealand College of Psychiatrists;
- Council of Procedural Specialists - membership includes:
  - Australian Society of Ophthalmologists,
  - Australian & New Zealand Society of Vascular Surgery,
  - Interventional Radiology Society of Australasia,
  - Australian Society of Orthopaedic Surgeons,
  - Medical Surgical Assistants Society of Australia,
  - Australian and New Zealand Association of Oral and Maxillofacial Surgeons,
  - Australian Society of Anaesthetists, Australian Society of Plastic Surgeons;
- Australian Society of Ophthalmologists;
- Australian Society of Orthopaedic Surgeons;
- Icon Group (employs 150 oncologists and haematologists across Australia);
- Spine Society of Australia (SSA);
- The National Association of Specialist Obstetricians and Gynaecologists (NASOG);
- Australian Salaried Medical Officers' Federation (ASMOF) and
- The Australia and New Zealand Society of Vascular Surgery (ANZSVS).

The AMA urges the MBS Review Taskforce to consider the responses and issues raised by all craft groups, as this will obviously provide a broad perspective of practising specialist consultants, from a variety of specialties and sub-specialties and practice settings. Furthermore, the collective feedback will complement the views of the Committee, which appear to include a disproportionate membership of public health service sector and clinical academic representatives.

The SCPCCC not only reviewed 143 items related to attendances by specialist and consultant physicians, also herein referred to as 'specialist consultants', but it ambitiously proposes the follow structural reforms and initiatives:

- Replacing standard attendance, complex care plan and telehealth items with the same set of standard time tiered items;
- A new framework for case conferences;
- Use of data to inform and improve clinical care;

- Continuing Professional Development (CPD) education and item descriptors to improve informed financial consent;
- MBS requirements to incentivise use of My Health Record;
- Increased access by Allied Health Professionals and Nurse Practitioners to the MBS; and
- Consideration and changes to referral pathways.

The AMA would like to make the point clearly that this report is only a summary of the key issues, concerns and feedback raised by the AMA's members, Councillors and other professional bodies. If further consideration is going to be given with proceeding with some, or all of these recommendations, there should be a widely publicised forum, with adequate lead time to discuss them with the profession – before the MBS Taskforce considers them further, and it should include the necessary information which is missing from the report. The AMA is limited in being able to respond to the report more meaningfully due to these constraints, and in the absence of a compelling argument, backed with the data to allow modelling, disagrees with a number of the key recommendations outlined it the report.

Recommendations 1, 3, 4 and 5 - which proposes a move away from initial and subsequent attendance items, differential rebates for specialists and consultant physicians, and removal of additional payments for complex planning.

The AMA is unable to support the proposed time tiered attendance items given the significant concerns discussed below, the unknown potential impact on specialist consultants broadly, and on the various specialties more specifically – due in large part to the fact that no fees are proposed, nor any modelling provided.

The proposed reform of moving from initial and subsequent specialist and consultant physician attendance items to time tiered items is premised on the view by the SCPCCC that there is no longer any difference between consultant physicians and other specialists, as many consultant physicians now perform procedures. According to feedback from AMA members and relevant craft groups, such as the Australian Association of Consultant Physicians (AACP), this assumption fails to recognise that most consultant physicians continue to work in consultative practice.

Furthermore, whilst there are AMA members who see benefits of the proposed time tiering, the majority of the membership, both consultant physician and specialists, have raised the following concerns and questions regarding the proposal:

1. Time does not equal complexity;
2. Non-patient-facing time not adequately addressed;
3. Time tiering devalues efficiency and quality;
4. Not enough detail - no fees proposed and time tiers not appropriate;
5. Impacts on patients in rural/regional areas;
6. Unable to provide informed financial consent;
7. Should not be cost saving exercise, or a revenue neutral reallocation; and
8. Cases of inappropriate claiming should not be addressed by wholesale change.

Time does not equal complexity and non-patient face time not adequately addressed

Not only is there an increasing complexity of chronic disease and ageing amongst Australia's population, but the complexity of medical diagnostics and treatment has also increased with advances in technology and medicine. With this multi-layered complexity of burden of disease, and the diagnostics and treatment provided by Australian specialist consultants, time is only a partial indicator for complexity of the clinical cases and the 'depth of care' being provided. Time tiered attendance items, coupled with value placed *only* on patient facing time, does not adequately address the complexity of the clinical problem and the medical services provided by specialist consultants.

Therefore, the AMA believes that the SCPCCC report has recommended an overly simplified set of time-tiered attendance items, unsuitable for a significantly diverse group of medical practitioners who practise in a wide variety of specialties, service delivery models and settings (eg. varying proportion of Medicare billing; and services provided in consult rooms, emergency departments and wards of public and private hospitals). This 'one-model-fits-all' approach does not recognise the benefits of the current MBS structure for this group of medical practitioners and their patients, nor does it take into account the intricacies of the consultant specialist service delivery model. And the recommendations are put forward without any evidence that the proposed restructure will deliver any demonstrable improvement.

For example, time tiering does not account for the many shorter consultations that require a large amount of preparatory and/or follow up work – the majority of which does not involve being physically present with a patient. The time-tiered model does not appear to adequately provide for time spent before or after the consultation (e.g reviewing literature, chasing previous results, reports from other specialists/GPs, dictating letters, reviewing letters, referring to other sub-specialties, discussing complex cases with colleagues) within the item descriptor. This is particularly relevant for specialists such as oncologists, physicians, paediatricians, geriatric medicine specialists, infectious disease specialists, endocrinologists and ophthalmologists.

Furthermore, privately practising specialist consultants provide care around the clock, without the support of registrars, residents, public emergency departments and other major support services and infrastructure often available to publicly funded specialist consultant services. Feedback received indicates that the current MBS specialist consultant standard and complex attendance structure go some way to providing appropriate reimbursement, noting that the time spent in consultation is only a small aspect of the care provided – and yet the AMA does not get the sense in the report that this will be adequately covered under the new structure.

Whilst the proposed timed tiering is modelled on the GP attendance items, specialist consultations differ greatly to GP consultations, in terms of complexity, and this time tiered payment does not acknowledge time spent beyond the initial consult. For example, a typical medical oncology consultation is a very complex process. Seeing the patient in the room is only part of the process. After the consultation, the patient may spend anytime between 3-5 hours in the department for further treatment. Prescribing chemotherapies and the new targeted treatments/ immunotherapy takes time and often involves ringing Medicare to get approvals. Writing a script for a specialised drug involves writing the script, filling out the necessary

paperwork explaining to PBS that the drug is still working, attaching all CT reports, and then sending this all to PBS in a written format (all part of ensuring appropriate use, in line with Government policy).

Time tiering must take into account and value non-patient time. However, non-patient time varies between practice models, and between specialties, and regions/patient cohorts, and would therefore need separate items to remunerate for this.

The issue raised by some consultant physicians that the current structure whereby the initial consultation is considered to always be longer than subsequent consultations can be addressed by introducing greater flexibility around the rules for initial, and follow-up, consultations. This can occur without encouraging inappropriate use of items.

Significant risk of the new time tier is that it may not adequately remunerate attendance of complex patients and may incentivise specialist consultants to take on a high volume of low complexity clinical cases over the highly complex (e.g. multimorbid and/ or frail elderly patients). While the AMA notes that the report says that non-patient time will be taken into account in the fees, we also note the report also says the item descriptors will not reflect this, and that the committee cannot comment on fees.

Time tier devalues efficiency and quality

The timing of consultations devalues and does not promote efficiency e.g. someone taking 35 minutes vs 45 minutes for a complex new case review, and questions remain as to what can be meaningfully achieved in the less than 5 minute consultation as proposed - particularly considering the push by all organisations in the health space to incentivise high-quality care.

Time tiering only values the process, and not the inputs or outcomes of a medical services. It does not value the extensive experience, clinical aptitude, interactions with colleagues that improve the service delivered, nor the continuous education and assessment that protect the quality of specialist consultant services. Consequently, the time-tiered system has the potential of rewarding specialists with less medical experience who may require more time with patients, as opposed to more experienced professionals who can be more efficient. The impact that “clock watching” could have on the patient experience and amount of time that a patient spends with their specialist consultant should be considered.

Not enough detail - no fees proposed and time tiers not appropriate

The AMA notes that the Committee accepts that there is a lack of data on the current duration of consultant specialist attendance times and the activities performed in these attendances. The Committees also notes that this lack of data reduces the ability to accurately set time tiers and proposed schedule fees, and to predict the impact of these recommendations on individual specialties.

Despite this lack of data, the Committee recommends introducing time-tiered attendance items and then suggests the collection of data to assess the impacts on service volume, benefits, patient

out of pocket costs and patient experience, outcomes and access to services. Surely, these issues and the potential for unintended consequences are too significant to leave to chance with an 'implement and see what happens' approach – data must be provided, as must fees, and the profession allowed the time to model the impacts and give considered thought to potential positive and negative impacts.

The AMA is supportive of simplification of the MBS, however, as consistently stated the Review and its proposed changes should not simply be a Government savings exercise. The time-tier fees should be not be redesigned to be cost neutral overall – all that achieves is cutting the rebates for a great number of consultations. Without seeing the proposed fees, no modelling can be undertaken – and the experience of non-GP specialists of the review to date has been one of savings, not significant additional investment. Moving from a few items to many also seems to add complexity to the system.

Current service delivery models for rural/regional areas

The AMA and the Rural Doctors Association of Australia (RDAA) are concerned about the potential unintended consequences for rural specialist consultant services. One common service delivery model for specialist consultant services in rural communities is where metropolitan based specialist consultants provide the initial consultation (item 104) and subsequent patient care is handed back to the local GP for appropriate management.

Such an outreach model is important, and it is unclear how moving to time-based consultations may disincentivise the provision of these services by specialists to rural communities. The AMA has been advised by the RDAA that this risk is real, significant and there is a concern that once a specialist service is lost to a rural community, it is very difficult to reinstate.

The AMA understands that the RDAA has recommended that a rural loading to all specialist/consultant physician services be applied to ensure that there continues to be a financial incentive to provide services in rural communities.

Unable to provide informed financial consent

The AMA supports and promotes informed financial consent (IFC) as stated in its position statement, available here. IFC is a dialogue undertaken between a medical practitioner and a patient, so that the patient understands and consents to the potential fees for a medical service.

A number of AMA members have expressed concern with the reduced ability to provide IFC for their patients under the proposed time tiering, as it is will be impossible to predict the duration of consultation before the consultation commences. This is contrary to the objectives of the SCPCCC report recommendations. The AMA also notes that there has been extensive policy work undertaken by the Government to increase the visibility of fees, including initial consultations, for patients through the establishment of a Ministerial Committee on Out of Pocket Costs, and more recently a Reference Group and a separate Working Group on the same topic. A structural change to the initial consult items to introduce time-tiering creates an additional level of unpredictability for patients with regard to out of pocket costs.

Furthermore, some AMA members have raised concerns that the consultation with patients may be turned into a difficult process, where, if a consultation is to be extended for clinical reasons, additional discussions around price will have to be had with patients.

Additionally, not enough due consideration in the process has been given to patient needs and patient outcomes. Socioeconomically disadvantaged groups have poorer health status. This is well understood internationally and is, regrettably, true in Australia[1]. Most relevant to the proposed MBS time tiering, the same AIHW report (2018) found Australians from low socio-economic groups were less likely to act to prevent disease or detect it an asymptomatic stage.[2] The proposed shift to time tiered MBS specialist items could, therefore, disproportionally have a negative effect on the very group of low socio-economic patients who present to specialist with already advanced diseases/conditions which require longer specialists consultations – unless such consults are bulk billed, or the potential gap is smaller under the new structure than the current one. Without seeing the proposed fees, it is impossible to tell, and the AMA's concern is for this cohort of patient, who are least able to pay higher contributions arising from time tiered care. New treatment costs and new cost barriers for the sickest, most vulnerable patients in low socio-economic groups would be the very worst type of perverse outcome of the MBS review. If there is not great care in how this is managed, it could inadvertently push people into the hospital out-patient setting or even EDs, instead of private practice which has the capacity and shorter waiting periods.

Patients with complex conditions and co-morbidities will be made to choose between spending more time with doctors that could lead to improved health outcomes, and saving funds - particularly if the MBS rebates are inadequate (due to fee setting, inadequate indexation or being frozen again at some point in the future).

Cases of inappropriate claiming should not be addressed by wholesale change

Some feedback has suggested that the inappropriate claiming of a 'new case' item instead of a follow up/ review item, discussed in the SCPCCC, should be considered a specific issue, rather than wholesale change to the whole section of the schedule. This is especially true noting the specialist consultant items have a quasi time-based system already - i.e. item 132 is at least 45 mins; item 133 at least 20 minutes. Specialist consultants who routinely see complex patients are not convinced the proposed system will adequately remunerate this more complex work versus other work.

If a change is made to these consultation items in haste which devalues the centrality of general practice, and combined with inappropriate changes to indefinite referral requirements, we will see the GP centric role of our health system significantly eroded. This should not happen and be guarded against wherever possible.

[1] Turrell G, Stanley L, de Looper M & Oldenburg B 2006. Health Inequalities in Australia: Morbidity, health behaviours, risk factors and health service use. Health Inequalities Monitoring Series No. 2. AIHW Cat. No. PHE 72. Canberra: Queensland University of Technology and the Australian Institute of Health and Welfare.
[2] ibid

Historically MBS rebates have included a cognitive component as well as a practice component. After 35 years of price regression since the introduction of Medicare in 1984 rebates have reduced to the point that in high overhead predominately outpatient specialities, time tiering of specialist consultations will completely decouple rebates from what is charged for the service.

Feedback from specialist consultants who are in favour of time-based attendance items, support it because they believe that that these items shouldn't be differentiated by new vs subsequent consultations. Some consultants feel that subsequent consultations can be quite complex, and there has been a pattern of lack of investment in specialist subsequent consultant attendance items. But many of those who did express support, did with many of the same caveats and concerns as those outlined above.

Recommendation 2 – Introduce New Attendance Items for Acute, Urgent and Unplanned Attendances

Recommendation 2 proposes the creation of four new time-tiered attendance items for specific situations where the attendance is acute, urgent, unplanned, and does not take place in the consultant specialist's consulting rooms or in the emergency department of a public hospital. The new items are proposed to have the same time tiers as standard tiered attendance items, but with higher schedule fee.

It should be noted that, as proposed, there is general lack of understanding among AMA membership regarding what setting this recommendation applies to, what this change will mean in practice and how it will be implemented (e.g. referral rules, what evidence will be required to substantiate claiming of these new items). There is a great variation among types of urgent, unplanned care that could potentially fall under these new items and so these items would need to be further clarified, such as listing examples of settings that these items apply in the explanatory notes.

Whether AMA members support the proposed change or not depends on their field of specialty, as well as type of service/treatment they are currently able to provide. For example, the proposed change is seen as good by some orthopaedic surgeons, who at the moment are not able to access emergency fees, but still attend to emergency admissions outside regular working hours. It is also seen as beneficial by doctors who are required to attend to patients in private hospitals who are in unstable conditions.

Some members argue that urgent treatment is provided in consulting rooms and that these settings should not necessarily be precluded. They contend that because of their ability to take on patients who present without referrals and who need urgent treatment, they enable savings to the public system by preventing these patients from presenting at public hospital emergency departments.

Recommendation 5 - Removing consultant physician, geriatric, addiction medicine, and sexual health medicine complex plan items and incorporating these into standard time-tiered attendances.

The AMA strongly opposes Recommendation 5 which proposes the deletion of complex care plan items and have them absorbed into standard time-tiered attendance items.

The rationale that complex planning items (132 and 133) are not used as intended because patients do not generally visit their GP within 6 months is curious, and likely false in many scenarios. For example, it could be argued that these patients have had all their complex care needs attended by the specialist, and there is good communication between the specialist and the GP occurring. That is, it is quite possible that the model of care is working – and a proposed change could well undermine that care.

The AMA also notes the commentary that attendance items are increasing. The AMA finds this unsurprising as with an ageing, growing patient population with an increasingly complex disease burden on the health system, an increase in attendance items is exactly what would be expected. It is no different from any other part of the health system – where we continue to see similar volume and patient complexity growth, across the board. A new structure, if contemplated, should be focussing on how to aid the profession in dealing with the issue.

AMA member geriatricians, geriatric psychiatrists and physicians oppose the proposed changes. They argue that moving to time based rather than complexity-based reimbursement does not factor in, or encourage, the quality and efficient complex care delivered to complex patients in specialist settings. This type of care cannot be billed based on time. Consequently, doctors who provide care for patients with multiple conditions and co-morbidities, such as patients in aged care for example, will be disproportionately disadvantaged with the proposed removal of consultant geriatric complex plan items and replacement by the introduction of time tiered attendance items – unless the fee setting is very well considered, and additional investment involved. Geriatric assessments are often very different from other standard doctor consultations and caring for patients with cognitive decline regularly requires significant input from family members and carers, as well as consultations with aged care providers, allied health, pharmacists etc, which will be hampered by the time-tiered consultations.

The increasing complexity of patients' medical problems requires medical practitioners to spend time to manage these. For example, it may take more than 2 hours to complete a history and examination with a patient, before management plan can be formulated.

Some members are concerned that the removal of the 141 item number will disincentivise seeing complex elderly patients, particularly those with dementia who require very intensive and time consuming work. Members have stated that if appropriately renumerated rebates are not available, the number of elderly clinic patients seen will be reduced. Specialist consultants who work in a rural area say that the demand for complex care of elderly patients is enormous and reduced Medicare rebates will make the provision of these services unsustainable.

In addition, our members are concerned that implications of the policy changes to the public system were not sufficiently considered by the MBS Review Committee and how the proposed changes may disincentivise doctors from caring for patients with complex conditions. Additional payments for complex planning is important, as not all patients belong to simple low risk

category. The changes introduced may lead to doctors in the private health system focusing primarily on patients with less complex conditions.

Other unintended consequences are that many consultant physicians do not attract patient Medicare rebates from procedures and rely on the extra loading of 132 and 133 item numbers, and removal of these items is likely to disincentivise non -procedural specialities.

Recommendation 6 - Appropriate access to paediatric complex plan items

Some AMA members are supportive of the proposed changes to the item 135 descriptor, noting that the current 135 descriptor is in need of updating. However, they note the absence of paediatricians in the MBS review committee and warn that without changes to fees provided at this stage, are not able to provide more feedback. Our members support the increase in rebates for this item.

Recommendation 7 and 8 – A new framework for telehealth and reinvest in non-MBS mechanisms

The AMA objects in the strongest of terms disinvestment of specialist MBS funding away from direct patient care to education and training. It is counterintuitive to remove existing incentives, that effectively support the delivery of front-line patient services and replace it with indirect and supplementary initiatives. These two policy levers, instead, should be used in conjunction and complimentary to each other.

Furthermore, the concerns raised above regarding the proposed time tiering for in person consultations, also applies for the proposed time tiered telehealth services and while not restated here, is reaffirmed.

The new proposed framework for telehealth is seen by AMA members as inappropriate because it will deter, rather than encourage, clinician engagement in telehealth. AMA members who use telehealth find it useful and beneficial for their patients living in rural and remote communities. They indicate that current telehealth arrangements allow them to bulk bill patients in rural and/ or indigenous communities, at the same time enabling these communities the access to a multidisciplinary clinic. Consequently, they argue, proposed changes will disproportionately and negatively affect these communities who are already disadvantaged and have poorer health outcomes.

AMA members who use telehealth do not accept the Committee's views that telehealth services have lower associated costs than in-person services. Members contend that consultations require extra time, effort and increased medico-legal risk for the provider and the 'set-up costs' were compensated for with an initial grant for technology, but the ongoing costs for this modality remain greater than standard in-person consultation.

The AMA notes that the report cited a slowing of telehealth uptake and that the telehealth loading is no longer incentivising additional uptake. AMA members contend that the level of uptake of telehealth by medical professionals should not be the only measure taken into

consideration when redesigning this policy. Analysis of data available on health outcomes for patients accessing this service should be taken into consideration, and no such attempt is made by the Committee report. Furthermore, there is significant risk of unintended consequences of this recommendation, if adopted, to reduce specialist consultant attendance services to rural and remote and Aboriginal communities.

As stated above, the AMA requests the continuation of MBS incentives for telehealth specialist consultations, that is supported by non-MBS mechanisms as proposed in Recommendation 8 of the SCPCCC report. Accordingly, the AMA suggests that the current Australian Digital Health Agency (ADHA) work in this space should be leveraged. The AMA has been closely involved with the ADHA, who is undertaking the kind of non-MBS work, with PHNs, clinicians, educators and in information provision on the My Health Record. It is concerning to the AMA that there is no discussion in this section about the ADHA experience, success rate or potential to leverage off this work, in communicating the closely related topic of telehealth via the exact same channels. The My Health Record experience can be instructive here for the Department.

The AMA cannot assert strongly enough that Recommendations 7 and 8, should not be an 'either or' proposition. That is, additional education, communication and information should be undertaken, without a cut to the MBS being required in order to do so.

Recommendation 9 - Introduce a new framework of case conference items and allow access to all consultant specialists

The AMA does not oppose the new framework for case conferences as it aligns with the AMA's position regarding the centrality of General Practice and patient-centred care. The AMA supports patients having the opportunity to be involved (unless there is a valid clinical reason for them not to attend, which must be documented) in a multi-disciplinary case conference. Being involved empowers patients as a partner in their health care, provides assurance that their views and goals contribute to decision making process, and may strengthen the relationship between the patient, their doctor and the rest of the health care team.

However, there is no mention of patients who are unable to participate in their care planning, for example patients with dementia, or for other reasons. This must be acknowledged and guidance on how to proceed provided in their absence.

Furthermore, the practicalities of the proposed item descriptor that require GPs and patients to be invited to attend community and discharge case conferences require further discussion. Having to coordinate separate meetings that align the availability of busy GPs, and patients, would be logistically and administratively complex. The case conferences would then either not occur or the scheduling and timeliness of case conference meetings would be significantly delayed and blown out.

The AMA also requests clarification on the requirements to substantiate the claiming of the proposed new case conference items.

Recommendation 10 - Introduce case conference items for allied health professionals (AHPs) and nurse practitioners (NPs)

The AMA supports Recommendation 10 of the SCPCCC' report as per the AMA's response to Recommendation 9 of the General Practice and Primary Care Clinical Committee (GPPCCC): Phase 2 report (submitted in February 2019 and available here), and restated as follows:

"The AMA has no objection to AHPRA registered allied health professionals privately practicing and who are a member of the patient's health care team being granted access to a rebate for participation in multi-disciplinary case conferencing.

"The AMA is concerned however that the proposed new explanatory note as per Recommendation 9 on pages 45-47 of the GPPCCC Phase 2 Report requires each provider participating in case conference to seek the permission of the patient. This is an impractical requirement for both the providers and on the patient, and it should only be the responsibility of the coordinating practitioner to obtain the patient's, or the consent of the carer authorised to make health decision on the patient's behalf (if appropriate) for them to participate. We are also concerned that requiring every participant to make a recording of the meeting is unnecessary. This may make the process too onerous and promote administrative compliance over patient care."

Recommendation 11 – Referral for examination of informed financial consent

The AMA notes, from the SCPCCC report, of the 26 million specialist consultant attendance MBS services claimed in 2016/17, only 1.3 percent (350,000 services) were for case conference services.

The AMA is not opposed to the recommendation for the Principles and Rules Committee (PRC) to examine the issues of informed financial consent for out-of-pocket fees charged with case conference items. The AMA understands the Committee is concerned about the potential increased usage, if access to case conference items are expanded to all consultant specialists and introducing access to AHP's and NP's.

The AMA, however, requests the PRC and MBS Review Taskforce to balance these concerns against the view of some specialist consultants that the case conference items, as they stand, are inaccessible and are not often claimed even when these services are provided. Moreover, if the new framework for case conference items makes these items even more unwieldy and restrictive, the proposed changes will do nothing more than prevent more patients from accessing these rebates. AMA members have commented that case conference items, if used appropriately, can be an important part of improved patient care, particularly for cancer patients, and changes should be about increasing their appropriate use.

Recommendation 12, 13, 14 - Establish A National Minimum Data Set To Inform Evidence-Based Clinical Practice And Inform Patient Choice; Provide transparency on the cost and quality of consultant specialist services; and Improve Informed Patient Consent And Shared Decision-Making Practices

The AMA supports data driven quality of care improvement. However, recommendations 12, 13 and 14 are beyond the scope of the MBS Review. The Taskforce is tasked to consider how items on the MBS can be better aligned with contemporary clinical evidence and practice, and improve health outcomes for patients, and identifying whether there are any services that are obsolete, outdated or potentially unsafe.

Whilst the Committee states that it does not consider the MBS the primary vehicle for addressing quality care and IFC issues, it proceeds to make both MBS and non-MBS recommendations. The AMA strongly believes it is not the role of the MBS Review Taskforce to venture into the purview of policies and strategies, outside of changes to the MBS being prepared for Government consideration. In many ways, it does appear there has been scope creep.

Recommendation 14 - Informed Financial Consent and Out of Pockets costs work already underway

Significant work regarding patient informed financial consent and out of pocket costs has been undertaken in recent years by Government (Ministerial Committee on Out of Pockets Costs, and now the establishment of two new groups), medical colleges, the AMA and other peak bodies. The AMA is currently leading work and in collaboration with colleges, associations and societies to improve informed financial consent and address out of pocket costs. Again, the reviews consideration of this appears not to be linked in with this existing work.

Clinical quality registries or other benchmarking mechanisms already underway

Contrary to the claim in the SCPCCC Report, many specialists already participate in clinical quality registries or other benchmarking mechanisms to measure their performance against that of their peers. The Australian Orthopaedic Association's National Joint Replacement Registry (AOA NJRR) has been highlighted as a world-leading registry that has changed the practice of orthopaedics in Australia and around the world and saved government and the public hundreds of millions of dollars as a result. The AOA NJRR has recently commenced providing feedback to individual surgeons on their joint replacement revision rates compared with their peers. This is a clinician led initiative, premised on the evidence that shows clinicians, are most likely to accept and act on benchmarked data, if the benchmarked methodology is clinician led and the outcomes are delivered from a clear position of beneficence.

A government led agenda to broaden the number and scope of clinical quality registries is being progressed by the Health System Financing and Evaluation branch of the Department of Health. A stakeholder consultation is currently underway to introduce a Clinical Quality Registry – National Strategy. For a complete and detailed AMA view on using data to improve quality of care, see the AMA submission on Australian Clinical Quality Registries – A National Strategy.

Significant risks with recommendations 12 and 13 as proposed and via MBS Review process

Recommendations 12 and 13 are significant reforms that should be discussed via an alternative mechanism to the MBS Review. There are significant risks to collecting, interpreting and

presenting complex process and outcomes data, with limitations and caveats that need be considered. The AMA maintains it is potentially dangerous to present such complex and imperfect data to members of the public, where we know health literacy is variable. Furthermore, this work appears to not consider in detail the work done already by AIHW, ACSQHC and in the private health space.

The AMA sees the long-term merit in establishing a national minimum data set, but such a data set should never be used to drive and/or prescribe clinical scope of practice. The idea that all clinical variation is bad is naïve at best and potentially detrimental to patient safety. Not all clinical variation is bad. Good variation is what makes excellent patient centred care.

Bureaucratic attempts to drive clinical practice and limit clinical variation via prescriptive medicine carries a very real risk that services will be provided to patients that do not need it, and treatments withheld from patients who would benefit. In either case the impact on patients is negative.

Example - Limitations of Atlas of Variation

The AMA notes the Australian Commission on Safety and Quality in Health Care (ACSQHC) produces the Atlas of Variation. The AMA has serious concerns about the specificity of changes to clinical practice recommended by the Commission in the Atlas series, despite the data limitations that informed these recommendations.

For example, the Atlas presents variation in healthcare utilisation by geographic region (Statistical Area Level 3). The data sets capture some, but not all, of the patient's symptoms, additional conditions, and severity of these present at the time of the clinical intervention. Nor do the datasets in of themselves, contain the detailed clinical information needed to make a valid assessment of the appropriateness of the clinical care provided to the patient in conjunction with the patient's informed treatment preference.

A good example of this type of over-reach is the recommendations by the ACSQHC related to a reduction in early planned caesarean section 'without medical or obstetric indication'. The data set upon which these recommendations were based, had serious limitations.

In December 2018, the AMA responded to the release of ACSQHC's third Australian Atlas of Healthcare Variation with the following key remarks:

"It is very important for policymakers to be clear what the Atlas data is and isn't. It is good at highlighting variation in health utilisation at a regional level, but it is not good at explaining why. Clinical variation data must be considered a statistical guide only and is definitely no substitute for clinical experience and expertise".

The MBS Review Taskforce should be extremely cautious about the limitations and pitfalls of assessing and interpreting clinical practice variation. Medical practitioners already use data to improve their performance and will continue to do so. The AMA supports better use of data as it

has the potential to lead to improvements in clinical decision-making and the allocation of medical services.

The AMA believes using MBS data to analyse a doctor's quality or performance is fraught. The AMA believes that this is almost impossible to measure accurately independent of the team a practitioner works in, or the facility where they practice, or the characteristics of the patients they see. We have real concerns about whether this would really help or whether it might actually act to reduce the access of high-risk patients to care.

The AMA does not want to see doctors being concerned about misleading statistics being publicised and being attributed to them – when in reality many complications, readmissions and other adverse events can be factors relating to the disease profile of the individual, their compliance with a treatment plan, the wider medical and carer team, and the facility.

Recommendations 15, 16, 17 - Case Conference Use of My Health Record (MyHR) and incentivise/ encourage adoption of MyHR

The AMA supports the My Health Record and does not oppose financial incentives to encourage specialist uptake of the My Health Record. However, the AMA believes that the implementation of MyHR is too early in its implementation to link specialist MBS item rebates with specialist use of the My Health Record, without also addressing other related issues regarding uptake.

The AMA notes that the opt out period ended on 31 January 2019 and at the time of opt out specialists who had connected to the My Health Record remained in the minority. A large part of the explanation for the slow uptake of the My Health Record amongst specialists is the lack of interoperability between specialist clinical software and the My Health Record system. The Australian Digital Health Agency has only recently established a working group to focus on secure messaging and interoperability and its first meeting was scheduled for 29 April 2019.

It will take time and investment to resolve the very challenging, technical problems that block interoperability between the thousands of different clinical software packages used across the health system. It makes no sense to rush to penalise specialists who by virtue of the type of clinical software relevant to their area of specialty, cannot yet seamlessly connect to the My Health Record and utilise the full functionality the Record offers.

Recommendation 18 - Retention of The Specialist-To-Specialist Referral Validity to Three Months.

The AMA generally supports this recommendation as it aligns with its position that GPs should be the point of care and coordination for patients. However, the AMA suggests that whilst the default validity period for specialist to specialist should remain at three months, an option should be made available for the validity period to be extended beyond three months where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions. Circumstances that may require long term management and consultation attendances over an extended period of time include, but not limited to, patients with Parkinson's disease and cancer.

The AMA notes, as stated in the Medicare rule GN.6.16, that *"the referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral."* Consequently, the time between initial consultation service provided by the referred specialist consultant covered by the referral can be greater than 3 months. It also noted that this recommendation relates only to services that require a referral (ie excludes non-referred items such as those in T8 surgical operations group of the MBS).

Recommendation 19 - consultant specialists to have access to a small number of "Allied Health Professional bridging referrals" that are eligible for a rebate, but only after a full review of the evidence and the associated costs and benefits of any suggested pathway.

The AMA notes that currently consultant specialists can refer to AHPs but without access to a Medicare rebate, but if this recommendation is adopted a patient rebate will be made available via a consultant specialist referral. Under the current MBS structure, for patients to access a rebate, they must be assessed by their GP for eligibility and development of a GP Management Plan (item 721). If granted, the patient can access up to five AHP visits with a rebate.

The AMA acknowledges that specialist's referral to allied health is an important part of patient management and patients are much more likely to follow through if there is one less hoop to jump through. The AMA supports this recommendation in principle but requests evidence of how this policy change would not detrimentally impact upon the GP as a central component of a member's health.

Furthermore, consideration needs to be given with regard to the impact on the current partial subsidy provided by some health funds, depending on a patient's policy, towards these services.

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