Consumers Health Forum of Australia

SUBMISSION

CHF Response to the Report from the Specialist and Consultant Physician Consultation Clinical Committee

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Consumers Health Forum of Australia 2019
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Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the diverse interests of Australian healthcare consumers and those with an interest in health consumer affairs. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems. We are pleased to respond to the Report from the MBS Review Taskforce's *Specialist and Consultant Physician Consultation Clinical Committee*.

Our positions are developed through consultations, research, and events like the Thought Leadership Roundtables involving consumers, health care providers, policy experts, academics and people in government. Further information about us and our publications can be found on our website, www.chf.org.au.

Thirty years following the creation of Medicare Benefits Scheme (MBS), a review is long overdue. CHF members believe that this review and a commitment to the regular evaluation of Medicare items is an essential to maintaining a world class health system and ensuring that funding is available for high value care.

General Comments

In the initial consultation CHF undertook on the MBS Review in 2015 consumers identified a number of problems with specialist/consultant physician consultations including referrals, access and price of those consultations. Consumers indicated that they found the referral system confusing, were unsure why initial and subsequent appointments carried different fee structures and queried the need for named referrals. CHF is looking for recommendations that simplify the rebates system so that consumers could have a better understanding of the rebate which would be payable for any given consultation.

Variation in, and sometimes poor access to specialists and consultant physicians comes up all the time in consumer feedback. People are concerned about how they choose a specialist of any description, what quality indicators they can use, and they are concerned about the costs, in particular the ever-widening out of pocket costs as specialist fees outstrip MBS rebates. CHF's 2018 Out of Pocket Pain Survey highlights this issue with many respondents singling out the initial cost of seeing a specialist/consultant physicians as a real barrier to accessing that care[1]. This comment sums up what many consumers find when they try to access a specialist:

"*Finding the $240 to start with is often difficult when you are a pensioner. There is variation on the amount of gap I pay depending on individual specialists and what they want to charge.*"

We know from the work of the Australian Institute of Health and Welfare that many people do not take up a specialist referral due to cost barriers. This has profound implications for their longer-term health care and health care outcomes, as well as the system if these people find

[1] CHF 2019 *Out of Pocket Pain and Hear Our Pain*

their way into the acute and hospital system with more complexity and morbidity to manage than that which they started off with.

Whilst CHF understands that the MBS Review was not charged with looking at out of pocket costs and cannot set specialists fees, the proposals for changes in the rebate structure, particularly the move to a time-based tiered structure, needs to consider the possible impact on out of pocket costs. This is something which needs to be built into future review of the changes and one that CHF will continue to monitor.

CHF commends the Committee on its work: if implemented the recommended changes to the specialist and consultant physician items in the MBS would greatly simplify arrangements and make them easier for consumers to understand and navigate. CHF is supportive of the general direction of the recommendations in the report and believes they have the capacity to improve access and consumers' understanding of the services being offered. We also agree with the appraisals given from a consumer perspective in the impact statement.

Response to the Recommendations

Standard Attendance: Recommendations 1-4

CHF supports in principle the time-based, tiered approach proposed as we believe that better reflects the services that consumers are receiving. We are particularly pleased to see the distinction between initial and subsequent or follow-up consultations removed as this has been a cause of confusion and complaint from consumers. For consumers it would provide greater assurance that the consultation will be tailored to fit their needs rather than being assigned a tag and a rebate level which many not reflect the care they need at that particular time.

We do have some reservations. Consumers are concerned about the potential for the tiered approach to increase out of pocket costs. They have raised the issue that there may be less certainty about the cost of a consultation and associated out of pocket costs as they do not know beforehand which tier it would come into. At the moment they know it is an initial or subsequent consultation and know the fee structure.

Some consumers have also indicated that they would be mindful of the length of a consultation and might not bring up areas of concern if they thought it would move the consultation time into the next tier. This would not enhance consumer care.

There needs to be a commitment to monitor the impact on out-of-pockets costs of the introduction of the tiered approach. There will need to be enhanced communication with consumers around expected length of consultation and appropriate informed financial consent prior to that consultation so that they can budget for the costs.

Whilst having a consistent rebate will not necessarily mean consistent fees for services it will provide a more equitable level of government subsidy for the services. It will make searching the proposed Government specialist fee website easier with the same rebate applicable across the board for a designated consultation

CHF supports the recommendation to have a separate set of rebates for unplanned or emergency attendances outside of the consulting rooms and acknowledges the need to set these rebates higher than for in room consultation. Hopefully these would offer an incentive for specialist to provide such services in settings such as residential aged care where there is currently poor access to specialist services.

Complex Plans: Recommendations 5 and 6

CHF supports the recommendations to remove complex plans items for the designated specialities and have these services refunded under the new standard tiered rebates. We accept the Committee's position that these items were used as surrogates for longer consultations and did not represent added value to the consumer that would not otherwise have been met by a longer standard consultation.

Similarly, we accept the need to keep a separate item for complex paediatric patients and support its link to allied health professionals.

Telehealth: Recommendations 7 and 8

CHF supports recommendation 7 which would align telehealth rebates with the standard consultation rebates.

This is a sensible approach and is consistent with the idea that the mode of consultation, i.e. face to face telehealth, should not determine the level of rebate. Indeed, in an ideal world there would not be the need to 'mirror' the standard consultation fee for these services but instead just allow them to be claimed. CHF has argued for some time about ensuring that services are agnostic in terms of how they are delivered. We have called for the extension of telehealth as it offers improved access to specialist services for many consumers , including but not limited to, people living in rural and remote areas. This recommendation would help facilitate that move.

CHF supports recommendation 8 to reinvest the savings from recommendation 7 into enhanced telehealth services. We need to build the use of telehealth and provide education on its use and benefits across the health system. This will particularly benefit people in rural, remote and regional areas and those who face challenges getting to face-to-face consultations such as mobility and access to transport. This will require additional resources and it makes sense that any savings from eliminating the telehealth loading as in recommendation 7 should be used to meet those costs.

We agree with the identified need to encourage utilisation of telehealth services by GPs, consumers and PHNs and increasing the numbers of specialist consultations offered this way. Strategies identified in the report will help address both of those objectives. As the report indicates, international evidence tells us that telehealth can save time and money once the benefits are understood and utilisation supported. However, we know that digital health literacy and the 'digital divide' is a real phenomenon and are therefore keen to ensure that consumers are made aware of the benefits of using telehealth and encouraged to see this service delivery as the first choice rather than feeling they are being offered a second-class service when it is offered.

Case Conferencing: Recommendations 9-11

CHF strongly supports all the recommendations: they will improve the use of case conferencing and facilitate more collaborative care models that meet the needs of patients with often complex and interrelated problems. The proposed three-part framework for remunerating different types of case conferencing – discharge planning; community case conferencing and treatment planning – not only reflect the contemporary roles and value that specialist and consultant physicians play, they also reflect contemporary consumer needs and the complexities our systems of care now need to manage. If implemented, we believe they have the potential to improve patient outcomes and experience through improved multidisciplinary care, transitions of care between and across services, and discharge planning.

We agree that the new items should encourage shared decision making with patients. Better provision for case conferencing with the right payment structure should also stimulate more effective use of the specialist and consultant physician workforce outside of hospitals by better linking them and their skills to general practice in order to strengthen primary health care and the comprehensiveness of care patients can receive in that setting. This is a good outcome from a system perspective: the evidence that if we invest in generalism and high performing primary health care, our system will be more efficient and effective. We would, however, question whether a fee-for-service funding model goes far enough in terms of more formalised shared care arrangements and consultation-liaison models of care.

The current items for case conferencing are complex and confusing. We know that the more complex options there are the less likely people are to feel confident in using them. As a result, the current item structure is more likely to inhibit multidisciplinary care than promote it. The streamlined approach outlined in recommendation 9 would achieve the aim of promoting case conferencing at the right time and for the right group of patients who could be seen to get the most benefits.

CHF strongly support the introduction of case conference items for allied health professionals and nurse practitioners as outlined in Recommendation 10. We want to see more multidisciplinary care and the extension of case conference items to these groups of service provider would help facilitate that.

We also support Recommendation 11 which looks at informed financial consent for case conference items. As our research into the consumer experience of out of pocket costs showed, there are is varying commitment to, and practices around, meaningful informed financial consent. Any service which involves more than one health professional has the potential for multiple separate bills for the various component services. This can cause confusion and makes it hard for a patient to give informed financial consent as they may not have clear sight of all the fees to be charged and, in particular, the cumulative out of pocket impact.

Use of data to inform quality care and patient informed choice and consent: Recommendations 12- 14

CHF supports all these recommendations. If we are to have more patient centred care and patients participating in shared decision making we need to ensure they have access to good

information on what works and what doesn't. The recommendations in this section of the report would enable that to happen.

My Health Record: Recommendations15-17

CHF welcomed the inclusion of My Health Record into the deliberations of the Committee and supports all these recommendations.

A key part of the business case for My Health Record was the convenience it would offer consumers, the benefits it would bring to service providers who are part of their care and the reduction in system and care fragmentation it could facilitate. For My Health Record to deliver the full benefits to consumers it is imperative that specialists and consultant physicians participate by being prepared to upload onto patients' records and share information. Without their participation many consumers, especially those with complex and chronic conditions, will not have a complete or sufficient record of their health status and care.

The recommendations look to provide a financial incentive to adopt the My Health Record and then some additional support in using it. CHF is not well placed to comment on the levels of any payments, but they do need to be sufficient to truly offer an incentive. The equivalent payments for GPs have been criticised by the GP community as being too low and requiring very minimal outputs in terms of number of records uploaded.

Referrals: Recommendation 18 and 19

CHF's previous consultation in relation to the MBS Review reinforced a general lack of understanding of how the referral system works and a desire for some clarification and changes to make it more consumer friendly. The response from both the Principles and Rules Committee and this report to the referral issue is disappointing. Neither really addressed the issue of named referrals and the decision to keep the time limits on referrals does not address consumer concerns about unnecessary visits to the referring doctor when the condition is ongoing. Whilst the rationale for time limits is around continuity of care many consumers do not see it that way and raise issues around very perfunctory consultations to get the needed referral.

The report is quite dismissive of "consumer convenience" in terms of needing to get referrals renewed. For many consumers, getting that renewal costs time and effort as well as an additional doctor fee if they are not bulkbilled. For rural and remote consumers, it means travelling for appointments, with little or no financial support to undertake that travel. It would have been helpful if the recommendations on telehealth later in the report included referral renewal consultations.

CHF supports the intent of Recommendation 19 as we recognise the important role allied health professionals can play in improving the health and well-being of people with complex and chronic conditions however we think the recommendation is a bit cautious in seeking a further review as we believe the evidence is there. We are assuming the Committee either did not have the time to undertake the review of the evidence or thought this was outside of its scope. We would urge the Government to commission the further review as recommended as a matter of urgency as we think this is an area of need for consumers.