



PalliativeCare
AUSTRALIA

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AK MC (Retd), Governor-General
of the Commonwealth of Australia,
Patron*

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Professor Bruce Robinson
Chair Medical Benefits Schedule Review Taskforce
Department of Health
CANBERRA ACT 2600
Via email: MBSReviews@health.gov.au

Dear Professor Robinson,

Feedback on the Report from the Specialist and Consultant Physician Consultation Clinical Committee to the MBS Taskforce

Thank you for the opportunity to respond to the Report from the Specialist and Consultant Physician Consultation Clinical Committee to the MBS Review Taskforce (the Report). This is the fourth submission Palliative Care Australia (PCA) has made to the MBS Review Taskforce (Taskforce) following our other submissions:

- Report from the Nurse Practitioner Reference Group (June 2019);
- Report from the Pain Management Clinical Committee (April 2019); and
- Preliminary Report on urgent after-hours primary care services funding through the MBS (July 2017).

PCA is the national peak body for palliative care in Australia, providing leadership on palliative care policy and community engagement. Working closely with consumers, its Member Organisations and the palliative care and broader health, ageing and disability workforce, PCA aims to improve the quality of life and death for people with a life-limiting illness, their families and carers.

As an overarching consideration of this Report, PCA supports the goals and objectives included in the National Palliative Care Strategy (2018) which represents the commitment of the Commonwealth, state and territory governments to ensuring the highest possible level of palliative care is available to all people. Within this Strategy, there is specific reference to funding mechanisms, including MBS items, to facilitate collaboration and care coordination across all settings.¹

The Report has provided another opportunity to highlight the significant pay disparity between the MBS items and benefits available to Fellows of the Royal Australasian College of Physicians (FRACP) and Fellows of the Australasian Chapter of Palliative Medicine (FACHPM). For example, (and as noted in our submission to the preliminary report on urgent after-hours primary care services funding through the MBS), item 132 (referred Patient Consultant Physician Treatment and Management Plan, fee: \$263.90) is available to Fellows of the RACP, where Fellows of FACHPM are currently omitted and can only access item 110 (fee: \$150.90) or item 3005 for palliative medicine attendances (fee: \$150.90) under the current MBS provisions. Highlighting that this pay disparity issue has been a recommended action to address within the Draft Report of the Pain Management Clinical Committee previously (items 132 and 133 specifically), PCA urges the

¹ National Palliative Care Strategy (2018), Goal 4 (Collaboration), Priority 4.4 (p.19)

Taskforce to be consistent during final deliberations within this Report, and all future work to ensure the FACHPM palliative medicines specialists are treated equitably with Fellows of the Royal Australasian College of Physicians (FRACP) and supported and recognised to continue their highly skilled and valued work.

Broadly PCA supports the view put forward in the Report, that the assumptions underlying the differentiation between specialist versus consultant physician attendances may no longer hold true due to evolution of medical practice, and that this distinction is increasingly dissociated from modern clinical practice and unclear to consumers.

PCA offers the following response to each individual recommendation made in the Report, which has been drawn from input provided through our Member Organisations, Affiliate Members and individual clinicians.

Recommendation 1: Introduce time-tiered attendance items

PCA generally supports the move to time-based consultations (both for general items and for telehealth options) as this reflects the nature of palliative care consultations and the person and family-centred approach that is the hallmark of palliative care, noting:

- Initial consults can be more complex, so while time tiered attendance items should be appropriate for most palliative care consults, the complexity and non-patient facing time required for an initial consultation may not always be adequately captured in a time-tiered system and it is essential that this is adequately reflected in the time-tiered item descriptors.
- The current item descriptors may not accurately reflect the nature of palliative care consultations. For example, the proposed item descriptors are focused on treatment options and plans whereas many palliative care consultations involve a considerable amount of time discussing goals of care and emotional, psychosocial and spiritual concerns associated with a diagnosis or progression of a life-limiting illness.
- The practice of palliative care medicine occurs in a range of settings (eg hospital, ambulance, community, correctional facilities and residential aged care) which may include varying consultation types such as initial reviews, follow-up, case conferences, and it is important that the MBS items are not restricted by location of consultation.
- The nature of palliative care may require effective management of multiple conditions and requires a team based approach involving specialist palliative care clinicians, other clinicians with a specialty area (e.g oncology, cardiology, neurology, gerontology) as well as primary care and other care providers, which must also be accommodated within the MBS to ensure appropriate specialty care is maintained.

PCA seeks assurance that the MBS structure will accommodate these factors, which are critical to palliative care consultations, and may form part of the informed patient consent and shared decision making practices (refer to recommendation 14).

PCA highlights that should specialty specific MBS items be replaced with general time-tiered attendance items, data will need to be captured to monitor the number and nature of palliative care and specialist palliative care consultations across Australia (refer to recommendation 3 and recommendation 12).

Recommendation 2: Introduce new attendance items for acute, urgent and unplanned attendances

PCA generally supports the introduction of these items subject to appropriate funding through the MBS schedule fee that recognises the associated costs to providing attendances outside of consulting rooms or emergency departments (for example if the consultant specialist is providing the service in a residential aged care facility or person's home).

PCA seeks assurance that the descriptors for these new attendance items for acute, urgent and unplanned attendances will allow for the nature of palliative care, where specialist care must be facilitated within non-acute settings and after hours, particularly towards the end of life and when a person is dying in order to provide care that aligns with the person's wishes and to avoid unnecessary or unwanted transfers.

Recommendation 3: Further considerations when implementing time-tiering

PCA supports the considerations highlighted in the Report that will need to be considered:

- a. Collecting data on the duration of attendances across specialties, and the activities performed during these attendances.
- b. Using the data to accurately model the impact of time-tiering on service volume and benefits;
- c. Investing in change management to facilitate transition to the new items and build understanding of the benefits of the time-tiering model.
- d. Making the model simple to provide transparency and consistency for doctors and consumers;
- e. Consideration of a longer time tier (ie Level F).
- f. Ensuring early, active and regular reviews of attendance items post implementation of time-tiering.
- g. Making the item descriptors sufficiently detailed to enable auditing through the review of clinical notes.
- h. Harmonising all attendance items tiers in the MBS that apply to other consultant specialists.
- i. Setting time-tiers that reduce the incentive for consultant specialists to claim a higher time-tier.

PCA considers an option for more than one hour consultation (the possible level F) should be available as there may be complex cases or situations where extra time is needed within a palliative consultation because of the difficult nature of the issues to be discussed and addressed.

Recommendation 4: Approach to fee setting

PCA commends the inclusion that fees will be set after building support among peak bodies, clinicians and consumers for the principles of time-tiering before introducing schedule fees. PCA supports the recognition that significant non-patient facing time is spent on each attendance reviewing complex patient records, test results and goals of care together with making necessary arrangements and referrals such as inpatient and outpatient bookings, home care, pharmacy consults etc for patients and their carers.

PCA requests that the Australia and New Zealand Society of Palliative Medicine (ANZSPM) and Paediatric Palliative Care Australia and New Zealand (PaPCANZ) are consulted on the schedule fees that may be utilised by palliative care specialists/physicians, and are able to assist in this process.

PCA has recently established a National Register of Palliative Care Consumers and Carers. Representatives on this National Register have a lived experience of palliative care including receiving care supported through the MBS. They also have an understanding of medical fees and out of pocket costs and PCA offers access to representatives on the National Register of Palliative Care Consumers and Carers for further consultation about a revised approach to fee setting as part of any changes to the MBS.

Recommendation 5: Removing consultant physician, geriatric, addition medicine, and sexual health complex plan items (MBS Items 132, 133, 141, 143, 145, 147, 6023, 6024, 6057, and 6058)

PCA understands that incorporation of complex plans will be accommodated in the proposed move to time-tiered attendances, where there is also recognition that items such as 132 were introduced with the intention that the creation of a comprehensive management plan by consultant specialists would enable ongoing management by the referring practitioner (usually the patient's GP).

PCA concurs that if the time-tiered attendances are appropriately funded through the MBS, and there is equitable access for Fellows of the Australasian Chapter of Palliative Medicine (FACHPM) and Fellows of the Royal Australasian College of Physicians (FRACP), the need for complex care items such as 132 and 133

which have been used by palliative care physicians will be suitably accommodated and funded by the time-tiered items.

While PCA is supportive of the general approach to move to time-tiered attendances, **PCA do not support a disincentive for geriatricians to complete Comprehensive Geriatric Assessments and seeks reassurance that the payment for the time-based tier systems will adequately reflect the time, skill level and complexity involved for geriatricians to complete these Assessments.**

Recommendation 6: Appropriate access to Paediatric Complex Plan items

PCA supports appropriate access to paediatric complex plan items and recommends specific issues including MBS item funding that may affect paediatric palliative care be directed to Paediatric Palliative Care Australia and New Zealand (PaPCANZ).

Recommendation 7 – A New Framework for Telehealth

Recommendation 8 – Reinvest in Telehealth

PCA generally supports measures to simplify telehealth consultations, and the proposed measures to reinvest all the savings from the telehealth loadings towards measures that will increase uptake of telehealth services in Australia.

PCA highlights the following issues with the item descriptors that limit the use of the items to patients who are located both (a) within a telehealth eligible area and (b) at the time of the attendance are at least 15 kms by road from a consultant specialist:

- Some palliative care patients who are unable to attend appointments from home or a residential facility or live on the other side of a jurisdictional border from the service, may have difficulty travelling to their consultant specialist even if the travel distance is short.
- In situations where rapid specialist palliative medicine responses are required and the patient is in their home, a telehealth consultation may avert an avoidable hospital admission and this can apply regardless of how close the person is in relation to the consultant specialist.

PCA recommends that in order to encourage telehealth uptake within palliative care situations, the restriction for the patient to be greater than 15 kms away from their consultant specialist should be removed for this specific purpose.

PCA is concerned that there may be an underestimate of the additional costs, infrastructure required and logistics involved in operating successful telehealth capacity.

PCA recommends that the aged care sector is added to the groups supported by the reinvestment of the savings to support and invest in the use of telehealth.

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

PCA recognises that there has been complexity and disparity in the MBS around case conferencing items and the rationale to simplify case conference items and involve GPs to a significantly greater extent. However PCA notes the following concerns with some of the aspects of the proposed case conferencing item framework:

- The extra workload and logistics required to invite a GP to each and every discharge and community case conference;
- The practicality of consultant specialists to follow up these requests to encourage GP participation;
- The complexity involved in having both patient and primary care provider plus other participants available at the same time;

- The time-critical nature of many palliative care case conference consultations which need to be organised quickly, particularly if it is at the end of life, which may not always require the GP to be actively involved;
- The extra involvement and remuneration required for GPs to review community and discharge case conference outcomes and upload to My Health Record on an ongoing basis; and
- The proposed restrictions on who needs to be in attendance may restrict optimal use of this important clinical activity, as case conferences are important tools in optimal palliative medicine and the attendees need to be tailored to the individual patient's needs and the nature of the issues which are being discussed.

In addition, it is not clear that the review of outcomes and communication also needs to be **sent** to the GP if they have not attended in person, where there is ambiguity in the recommendation where it states²

“Updating existing discharge and community case conference items.....Require:

1. Mandatory GP (or delegate) participation;
OR
2. Mandatory review of outcomes and communication of any proposed changes to the patient and to the case conference organiser.”

PCA also highlight the involvement of family members/carers in goals of care and advance care planning discussion with people receiving palliative care. Further, in the community it is often the family members/carers who are actively involved in the management of a person's condition including medication in the home environment, and as such is critical that they are involved in consultations with the patient.

PCA has noted throughout the Taskforce Review (and as part of other consultation processes) a concern regarding the inability of palliative care specialists to access the same MBS items for inpatient case conferencing and family meetings that rehabilitation specialists and gerontologists do (item 880 Case Conference by Consultant Physicians in Geriatric/ Rehabilitation Medicine, fee: \$48.65).

PCA recommends additional consultation with the medical profession, broader health, disability and aged care sectors and consumers regarding the logistics and practicality surrounding case conferencing and palliative care.

PCA recommends that item 880 be retained and seeks access to this item or a similar item for Palliative Care Specialists/Physicians and Nurse Practitioners.

Recommendation 10: introduce Case Conference Items for Allied Health Professionals (AHPs) and Nurse Practitioners

There are a range of people who work in collaboration in the provision of palliative care to a person with a life-limiting illness. AHPs such as occupational therapists, physiotherapists, speech therapists and social workers play an essential role, including support to manage physical symptoms, nutrition, communication and mobility in order to maintain function and independence, and sharing information relevant to disease progression to a person living with a life-limiting illness, their families and carers. Pharmacists also play an important role in the provision of medicines and medication management.

In line with PCA's submission to the Taskforce Nurse Practitioner report, PCA supports the inclusion of AHPs and Nurse Practitioners to be eligible to access MBS case conferences items.

² Report Page 57, point c (ii)

Recommendation 11: Referral for examination of informed financial consent

Recommendation 12: Establish a minimum data set to inform evidence-based clinical practice and inform patient choice.

Recommendation 13: Provide transparency on the cost and quality of consultant specialist services

PCA supports measures to ensure Australia has high quality data in relation to clinical practice and to help inform patient choice. As noted in the PCA submission to the Taskforce Nurse Practitioners Report, it is important that any changes to the MBS must include provisions to ensure appropriate data collection about palliative care consultations.

This is supported by the National Palliative Care Strategy (2018) which states the following priorities:

- 6.1. Nationally consistent data collection is used to monitor, evaluate and report on access to and outcomes of palliative care
- 6.2 Palliative care providers contribute to data collection, monitoring and reporting activities
- 6.3 Data collection and reporting informs continuous quality improvement of palliative care³

Without targeted data collection, and better data linkage across data sets there is an inability to accurately analyse how Australians access services, how many Australians receive palliative care and in what setting, what their preferences are for place of care and place of death and where they die. This data is essential if we want to understand and plan for palliative care needs for Australians into the future.

PCA recommends discussions with the Australian Institute for Health and Welfare who are currently developing the National Palliative Care and End-of-Life Care Information Priorities with the Palliative Care and End-of-Life Care Data Development Working Group, a committee of Australian Health Ministers Advisory Council (AHMAC) Health Services Principal Committee that reports to the Council of Australian Governments (COAG) Health Ministers.

PCA seeks further information on recommendation 13 on how this would be measured within the palliative care context where a person is likely to die, noting palliative care involves three equally important domains including⁴:

- early intervention to prevent or relieve distressing physical symptoms (such as breathing difficulties, pain, nausea, vomiting and delirium);
- the provision of psychological and spiritual support to reduce suffering and distress as people and their families cope with a life-limiting illness and in their bereavement; and
- social support to address problems related to the person's social and living circumstances, access to carers and their functional independence.

PCA supports the recommendation that the Principles and Rules Committee examine the issue of informed financial consent for out-of-pocket fees charged with case conference items.

Recommendation 14: Improve informed patient consent and shared decision-making practices

PCA supports this recommendation as good palliative care includes a collaborative decision-making approach that encompasses the life experiences and preferences of the individual, family, and the expertise of all clinicians and support providers involved, while also recognising that agreed goals of care may change over time. It is important to highlight that where an individual is not able to participate in care planning or decision-making, a substitute decision-maker or legal guardian is identified in accordance with the person's goals and preferences and relevant legislation and/or policies.

PCA recommends further discussions regarding the administrative process to support this measure for consultant specialists, and the varying levels of awareness and understanding by clinicians on best-practice and regulations surrounding consent and shared-decision making practices.

³ National Palliative Care Strategy (2018), Goal 6 (Data and Evidence), p.23.

⁴ Palliative Care Australia 2018, Background Report to the Palliative Care Service Development Guidelines, prepared by Aspex Consulting, Melbourne.

Recommendation 15: Case Conference use of My Health Record

Recommendation 16: Incentivise adoption of My Health Record

Recommendation 17: Encourage adoption of My Health Record

PCA supports the goals and objectives of My Health Record presuming it retains high functionality and there are guarantees of privacy and data security, and the recommendations for measures to incentivise and encourage the use of adoption of My Health Record.

As noted under recommendation 9, PCA is concerned about the resource implications of the extra administrative requirements for specialists to be mandated to communicate with GPs, and for GPs to take on a greater role in uploading some of the case conferencing records to My Health Record.

PCA recommends further consideration be given to the situation where a person does not have a regular GP or consent to the use of a My Health Record.

Recommendation 18: Retain the current specialist to specialist referral validity period

PCA acknowledges that the Committee has accepted the recommendation of the Principles and Rules Committee which has erred on the side of retaining the 3 month validity period for specialist referral to enable GP oversight of patient care provided by consultant physicians. However this is often problematic due to the delay in obtaining appointments for some clinicians, where the 3 month referral period can be very short and doesn't always allow for an initial referral and necessary review.

Recommendation 19: Introducing new Allied Health Professional (AHP) pathway

The coordination of care for people living with a life-limiting illness may be undertaken by a wide range of professionals across many organisations and settings. People will have different levels of need for palliative care, which may vary over time, increasing or decreasing in complexity. This includes:

- Those who provide palliative care as part of a broader scope of practice such as GPs, nurses, pharmacists, AHPs and aged care workers.
- Specialist palliative care team members including palliative care physicians, nurse practitioners, palliative care nurses, specialist AHP, grief and bereavement counsellors and spiritual care and pastoral care workers.

PCA supports this recommendation noting that specialist palliative care is based on team care with specialist and generalist AHPs, and recommends the development of such a pathway include GP and consumer input into the process.

In conclusion, the World Health Organisation⁵ have recently identified that there are a number of significant barriers which must be overcome to address the unmet need for palliative care, including national health policies and systems that do not often include palliative care at all, limited or non-existent training on palliative care for health professionals, and a lack of awareness among policy-makers, health professionals and the public about what palliative care is, and the benefits it can offer patients and health systems.

⁵ 1 World Health Organisation and Worldwide Palliative Care Alliance (2014) Global Atlas of Palliative Care at the End of Life ISBN: 978-0-9928277-0-0 [accessed online].

PCA aims to improve the quality of life and death for people with a life-limiting illness, their families and carers by improving access to, and promoting the need for, quality palliative care, and views the important work of the Taskforce and the various Committees as an opportunity to address a number of structural and policy-based issues in Australia, and to reach the goals as outlines in the National Palliative Care Strategy (2018). Thank you for the opportunity to provide this feedback. Please do not hesitate in contacting Kelly Gourlay, National Policy Advisor, if you wish to arrange to discuss these matters further on (02) 6232 0708 or kelly@palliativecare.org.au.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Rohan Greenland', with a horizontal line underneath.

Rohan Greenland
Chief Executive Officer
Palliative Care Australia