PalliativeCare
AUSTRALIA

His Excellency General the Honourable Sir Peter Cosgrove AK MC (Retd), Governor-General of the Commonwealth of Australia, Patron

Palliative Care Australia Incorporated
PO Box 24
Deakin West, ACT 2600
T 02 6232 4433 | F 02 6232 4434
palliativecare.org.au
pcainc@palliativecare.org.au
ABN 85 363 187 904

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Professor Bruce Robinson
Chair, MBS Review Taskforce
MBSReview@health.gov.au

Dear Professor Robinson

Medicare Benefits Schedule (MBS) Review Taskforce Consultation

I am writing with regard to the current consultation on the MBS Review. To date there has been no working group identified that is specific to palliative care. Palliative Care Australia would welcome the opportunity to make nominations to the working group with responsibility for considering MBS items relevant to palliative care.

It is important that people with expertise in palliative care are involved in decisions relating to palliative care MBS items. Should a separate working group not be established, we propose the inclusion of both Associate Professor Richard Chye and Professor Liz Reymond on the working group that will be responsible for consideration palliative care items. We would also appreciate if you would consult Margie Griffiths (Chief Pharmacist at Bairnsdale Regional Health Service), A/Prof Mark Boughey (Director of Palliative Medicine, St Vincent's, Melbourne) and Professor Geoffrey Mitchell (Professor of General Practice and Palliative Care, University of Queensland) to provide advice about the future of the palliative care MBS items.

Palliative Care Australia has identified at a high level some of the issues with the current MBS arrangements for palliative care in the attached document. However, this is a complex area which cannot easily be distilled into a brief document. Therefore, inclusion of people with expertise in provision of palliative care on the committee will be important in ensuring that all Australians are provided with high quality care as they approach the end of their life.

Yours sincerely

Liz Callaghan
Chief Executive Officer

1. General Practitioners (GPs) play an important role in the care of patients as they approach the end of their life. Development of an advance care plan requires commitment of time specific to that activity with the patient. Having a specific item for advance care planning would make the provision of this important service more visible to GPs and would enable greater promotion of the GPs role in advance care planning and management.

   Recommendation 1: Include new item numbers relating to the development and review of advance care plans by GPs (of similar time and value to those Items for chronic disease management).

2. Patients who have a chronic medical condition and complex care needs and are being managed by their GP under a GP Management Plan (item 721) and Team Care Arrangements (item 723) are eligible for Medicare rebates for certain allied health services on referral from their GP. This includes 5 MBS rebated referrals to allied health professionals each year. However, this cannot be accessed by palliative care specialists or nurse practitioners.

   Recommendation 2: Include in the MBS items referred to in Recommendation 1 the ability to refer to allied health professionals subsidised by the MBS.

   Recommendation 3: Palliative care specialists and nurse practitioners providing palliative care should be able to refer patients for five allied health visits subsidised by the MBS.

3. Many palliative care specialists that are registered with the FRACP use the general consultation MBS items (110, 116, 119, 132 and 133) rather than those for specialist palliative care physicians only registered with the FAChPM (3005, 3010). This may be because there are more options, including for a long consultation for the development of a patient treatment and management plan. This makes collection of data on the number of cases reviewed by palliative care specialists difficult. Further, geriatricians and rehabilitation physicians have case planning and discharge planning MBS items that are do not specifically mention palliative care.

   Recommendation 4: Develop items for use by FAChPM specialists for the development of a patient treatment and management plan (similar to 132 and 133).

4. Items (3018, 3023, 3028) are available for a palliative care specialist to make a visit to a patient at any place other than their consulting rooms. These items could be used for home visits or visits to any other community service such as a nursing home. These should remain.

5. Visits by other health professionals such as nurse practitioners do not have dedicated palliative care items, but existing items may sufficient to cover these services (82200, 82205, 82210, 82215). However, these item numbers may not provide appropriate remuneration. For example they may not provide sufficient remuneration for a palliative care nurse practitioner to sustain private practice or to support GPs making a home visit to a residential aged care facilities to provide palliative care. Further, while there are items to support a home visit, there are no items relating to coordination of care with the aged care facility. Ensuring GPs are supported to provide care in the community is important, and reimbursement needs to consider the earnings lost from not being available for consultations in their practice.

   Recommendation 5: Review the remuneration provided for home visits by health professionals such as nurse practitioners and general practitioners.

6. There are a number of items relating to palliative care specialists for palliative care cases organising case conferences (3032, 3040, 3044), participating in a case conference (3051, 3055, 3062), organising a discharge case conference (3069, 3074, 3078, 3083) and participating in a discharge conference (3083, 3088 and 3093). We understand that some of these are poorly used, and this may be due to the inadequacy of the funding to support someone to coordinate the care conferencing. Case conferencing is an important way to support community based palliative care and we propose that these items are enhanced by increasing the support for coordination of case conferences.

   Recommendation 6: Provide enhanced support for coordination of case conferences for palliative care.

7. There are no items that facilitate engagement with the families of a person with a life-limiting illness in understanding their care, and coming to an understanding of the goals of care for the consumer. Inclusion of an MBS item to have a family meeting would reduce the time required when there were disagreements between family members about the goals of care, and may lead to a reduction in provision of futile care.

   Recommendation 7: Include MBS items for family conferences to establish a common understanding about the goals of care.

8. There are a number of services identified as not attracting Medicare benefits, including issue of death certificates, cremation certificates and counselling of relatives.

   Recommendation 8: Review the services not attracting Medicare benefits under Note A3 of Category 1 Professional Attendances, to determine how medical practitioners can be supported better to provide high quality end of life care.