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

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Professor Bruce Robinson
Chair Medical Benefits Review Taskforce
Department of Health
CANBERRA ACT 2600

Dear Professor Robinson

RE: Urgent After-hours primary care services funded through the MBS

Thank you for taking the time to meet with Palliative Care Australia (PCA) to discuss the recommendations in the preliminary report on urgent after-hours primary care services funded through the MBS, released on June 7th 2017. As you are aware, PCA is the national peak body for palliative care in Australia and provides leadership on palliative care policy and community engagement. Working closely with consumers, Member Organisations and the palliative care and broader health workforce, PCA aims to improve the quality of life and death for people with a life-limiting illness, their families and carers.

Palliative care is for people of any age and is an approach that improves the quality of life of consumers and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of symptoms, pain and other problems, physical, psychosocial and spiritual. Dying is a normal process and palliative care offers a support system to help people to live their life as fully and as comfortably as possible until death, which often requires after-hours care.

PCA are of the strong opinion that when a patient receiving palliative care in the community requires after-hours care this should always be classified as 'urgent' and can never be delayed until the next in-hours period, whether delivered by the patients GP or a Medical Deputising Service (MDS). **PCA are calling for the inclusion of palliative care as a specific component within the definition of urgent in the proposed explanatory notes, and exemption to the availability of an MDS in the proposed item descriptors if the person requiring urgent after-hours care is identified as a person receiving palliative care.**

The PCA submission provides feedback on the preliminary report, following consultation with the PCA membership about the proposed changes to urgent after-hours services, and the potential impact on people living in the community or residing in residential aged care who may be at the end of their lives and require medical assistance after-hours. Any reduced access to urgent after-hours care in the community will leave people receiving palliative care and their carers in vulnerable situations where often the only option left is to present at emergency departments. PCA and its Members hear many stories of people nearing the end of their lives dying in the emergency department, or dying at home or within a residential aged care facility in pain. If beneficial to the

Medicare Benefits Schedule Review Taskforce, PCA are able to arrange a discussion with palliative care clinicians to relay these stories and discuss the issues directly.

PCA draws the Taskforce's attention to the *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Productivity Commission Draft Report* released in June 2017, which states that "without significant policy reform, tens of thousands of Australians will die in a way and in a place that does not reflect their values or their choices".

PCA is committed to working with the Government and the Taskforce to focus on:

- Ensuring there is adequate after-hours palliative care support in the community and that it is funded appropriately.
- Ensuring that the health system responds to the dying patient in the community and residential aged care in a way that adequately prioritises their care.
- Ensuring that all members of the population are enabled and supported to die in their place of choice.
- Supporting the work of MDS in the development of standards for care and a minimum training requirements to appropriately support people receiving palliative care in after-hours services.
- Ensuring that MDS's appropriately liaise with the patients GP and/or palliative care clinician in a timely manner.

It is also important that PCA reiterate to you and the Taskforce more broadly that Members have expressed their continued 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). As discussed with you at the meeting on the 5th of July, PCA believe that a review of this would be of significant benefit, with the view to extending access to palliative care specialists whose primary tasks often focus around the conduct of family meetings and case conferencing with other health professionals while a person is an inpatient. PCA would welcome the opportunity to work with the Taskforce to examine this issue, as well as the discrepancy in access to community-based MBS items. As an example, item 132 (Referred Patient Consultant Physician Treatment and Management Plan, fee: $263.90) is available to Fellows of the Royal Australian College of Physicians (FRACP), where Fellows of the Australasian Chapter of Palliative Medicine (FAChPM) are currently omitted and can only access item 110 (fee: $150.90) or item 3005 for palliative medicine attendances (fee: $150.90) which is remunerated at half the rate for the same activity.

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

Liz Callaghan
CEO
Palliative Care Australia

Palliative Care Australia's submission to the preliminary report for consultation: urgent after-hours primary care services funded through the MBS

The issue: lack of after-hours support in the community for people receiving palliative care

- The current approach to after-hours care in the community reflects the lack of an effective community based medical support system for people to die in the place of their choice - whether that be at home or in residential aged care.
- While 70% of Australians want to die at home, in 2015 only 15% did so[1].
- The needs of palliative care patients in the community, including residential aged care, must be prioritised. There is only one chance at dying well, and every person should be given the opportunity to be supported and cared for in a way that is evidence based, and to receive care in the setting of their choice if possible, without unnecessary emergency department visits in the after-hours period due to lack of access to medical care.
- Australia lags well behind other countries such as the United Kingdom, Ireland, New Zealand and France who all have considerably higher rates of at home deaths[2].
- Palliative care patient's needs are often under-recognised and do not fit well into any of the current after hour's processes funded through the MBS.
- To note that a significant number of GPs lack confidence in providing palliative care because of patient complexity, inadequate training and insufficient resources[3].
- Many GPs defer urgent after-hours care to a locum service or are willing to allow a medical deputising service (MDS) to see their patients, including those receiving palliative care. What is missing is access to the prior information including phone numbers for them to contact the patients usual GP in emergencies.

Reduced access to urgent after-hours care in the community will leave palliative care patients and their carers in vulnerable situations where often the only option left is to present at the emergency department. PCA and its members hear many stories of people nearing the end of their lives dying in the emergency department, or dying at home or within a residential aged care facility in pain.

- The evidence indicates that when palliative care is provided in the community, palliative care consumers are 87.5% more likely to remain in the community until death[4]. PCA believe that access to urgent after-hours care is a key component of any move to enable community-based palliative care.
- When people die at home, major savings usually accrue from their reduced use of hospitals and residential aged care. A study showed that the funds released from the reduced need for

[1]ABS (2016). *Causes of Death, Australia, 2015*. ABS Catalogue No. 3303.0, Canberra.
[2] Swerissen H and Duckett S. (2014). *Dying Well*. Grattan Institute, Melbourne.
[3] Le B et al (2017) 'Palliative care in general practice: GP integration in caring for patients with advanced cancer' *Aust Fam Phys* 46(1):51-55
[4] Aspex Consulting (2014). *The Australian Government Department of Health Analysis of proposed MBS items for Palliative Care. Final Report*. Commonwealth of Australia.

institutional care offset the costs of providing palliative care to more people at home, making this a cost neutral policy[5].

Potential impact of the proposed changes to the urgent after-hours item descriptors and explanatory notes for people receiving palliative care in the community

- PCA acknowledge the findings and concerns of the Taskforce, however, the preliminary recommendation of eliminating MBS item numbers 597, 598, 599 and 600 for MDS's and organisations that provide or facilitate medical services predominantly in after-hour periods, will not provide any new incentive for GP who's patients are currently receiving palliative care to provide urgent after-hours care.
- PCA consultations revealed that many palliative care services and GPs rely on urgent after-hours services such as those provided by a locum or MDS.

PCA strongly believe that when a patient receiving palliative care in the community requires after-hours care this should always be classified as 'urgent' and can never be delayed until the next in-hours period, whether delivered by the patients GP or an MDS.

PCA is concerned that removing the ability for MDSs to provide urgent after-hours visits to people receiving palliative care will undermine the current availability of palliative care support in the community, at a time when there is a general recognition that access to end-of-life care needs to be increased, not diminished

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- One of the current problems facing GPs in providing urgent after-hours visits is the low remuneration. Feedback to PCA is that these items are not viewed as cost effective for GPs or their practice and it is thus the business model to not provide after-hours visits even for patients who are receiving palliative care.
- There are only 242 specialist palliative care services across Australia, most of which are located in major cities and large urban areas.
- Patients who are attached to a palliative care service *may* be supported during after-hours in the community by that service, however most often there are MDS arrangements in place that support that community based service if and when required.
- People living within residential aged care facilities who may be nearing the end of their life should be supported by a palliative approach to care. Whilst residential aged care is not seen as a hospital they are increasingly expected to meet hospital type outcomes, particularly as they relate to end-of-life care.
- In *some* instances specialist palliative care services provide in-reach support to residential care services but this is the exception. Most often a resident is under the care of a GP who *may* do residential visits once a week to provide pain and symptom management.

[5] *Op.Cit* (2)

A proposed solution – maintain access to after-hours care for palliative care patients by leveraging off the infrastructure that currently exists through MDS's and improve the quality of care and communication with GPs and palliative clinicians.

- There is a need to maintain access to urgent after-hours care for people who are receiving palliative care in their homes (including residential aged care).

PCA call for an exemption to the availability of an MDS to the proposed item descriptors if the person requiring urgent after-hours care is identified as a person receiving palliative care.

- A system of notification by the patient's usual GP or palliative care clinician will be required to identify when an MDS is able to attend to the patient during the after-hours period.
- This system will need to include access to the persons relevant medical information to assist in the after-hours visit, as well as clear communication of outcomes, and/or the ability to contact the patient's usual GP or palliative care clinician by phone should this be required.
- If a GP or palliative care clinician is contacted in the after-hours period, an appropriate MBS item should also be made available.

Simultaneously, the provision of after-hours visits by the patient usual GP should be promoted, with investigation into the feasibility of a Practice Incentive Payment or other mechanism thought the MBS to provide such a service

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- PCA believes that the budget implications for the exemption for palliative care patients would be minimal when weighed against the savings of less ambulance transport and unnecessary hospitalisations, as well as the minimising the impact a painful death has on a person's carer and families and the avoidance of complex grief issues associated with this.
- PCA acknowledge that MDS services are often provided by less qualified clinicians, and believe this not only puts the patient at risk, but also represents less value for money to claim the higher rebate attached to the urgent after-hours items.

PCA call for approved compulsory training in palliative care for any MDS clinician that wants to provide urgent after-hours care, including upskilling in assessment and pain and symptom management

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- Arrangements would need to be put in place during a transition period that would allow current services to continue whilst training and associated processes were put in place so as not to reduce access in the interim.