RACGP

The RACGP's submission to the Medicare Benefits Schedule (MBS) Review Taskforce

1. The Review – Issues for stakeholder comment

1.1 Online questions

a) Do you think that there are parts of the MBS that are out of date and that a review of the MBS is required?

The Royal Australian College of General Practitioners (RACGP) acknowledges that the Medical Benefits Schedule (MBS) has expanded significantly over time to include medical services and technologies that have emerged since its introduction. The RACGP considers a comprehensive and rigorous review of the entire MBS is required as the majority of MBS items have not undergone evidence-based assessment.

The following factors must be considered when undertaking a review of the MBS:

- there is a lack of recognition for non–face-to-face time taken in providing patient care
- the MBS is difficult to understand and navigate, with little help available to assist in the interpretation of MBS items
- unnecessary red tape is placing a significant administrative burden on general practitioners (GPs)
- disparities in the value of patient rebates for GP and other medical specialist services persist
- patient rebates have not kept pace with the cost of delivering high-quality medical care
- there is no support to undertake care coordination activities in general practice
- the structure of rebates to support GP visits in residential aged care facilities (RACFs) is a disincentive
- restrictions on the use of telehealth and other forms of communication limit patient access to GPs
- differences between the legislation and regulations underpinning the MBS have resulted in inconsistencies in the recognition of GPs as specialists.

The MBS Review is an opportunity to modernise Medicare and ensure an effective and efficient use of scarce healthcare resources through the delivery of evidence-based, high-quality and safe patient care.

b) Do you have any comments on the proposed MBS Review process?

In regards to the overall review process, RACGP members have expressed support for the timeframes, structure and proposed evaluation of the MBS Review. Similarly, members have supported the use of electronic surveys to collect information from a broad audience.

When reviewing MBS items and patient rebates, the MBS Review Taskforce should take into account evidence for effectiveness, resources required to provide the service (including training and skill level), and the time involved.

Dedicated focus on general practice

As identified in the MBS Review consultation paper, general practice expenditure accounts for only one-third of total Medicare spending, yet this represents 140 million general practice consultations in the last year.[1] The MBS Review needs to recognise that general practice is unique among the medical specialties, most of which are procedurally focused. The MBS does not recognise the complexity of delivering quality general practice services, and a focused review of the specific general practice item numbers is needed.

The RACGP recommends a General Practice Clinical Committee be established to consider and provide advice to the MBS Review Taskforce on MBS items that directly or indirectly relate to general practice. Given their scope of practice and generalist expertise, GPs are able to provide valuable expert advice on equity of access, quality, safety, utility, practice costs, fee setting, and the clinical impact of changes made to the MBS.

Strong consumer representation

As the MBS determines patient rebates for consumers (which may or may not cover the complete cost of providing the medical service), the MBS Review Taskforce should ensure strong consumer representation and partnership throughout the review process.

Introduction of new items to the MBS

It is concerning that the MBS Review Taskforce has not specifically sought advice from stakeholders on new MBS items. This is a missed opportunity to understand which current and future services health professionals and patients believe require MBS support to meet community need.

Confusion among stakeholder groups about whether the MBS Review Taskforce is considering new items has not assisted in reducing skepticism that the MBS Review is solely about cost cutting and the removal of item numbers.

A history of incomplete MBS Reviews

It is worth noting that the MBS Review Taskforce does not represent the first attempt at reforming the MBS. The MBS Quality Framework (2010) and the Relative Value Study (1994–2001) were significant projects that resulted in no change to the arrangements for providing patient rebates via the MBS. The RACGP is keen to ensure that positive outcomes emerge from the MBS Review and that a sustainable process for regular review of MBS items and descriptors is established to prevent the need for these large-scale reviews in the future.

The review process must be transparent, bi-partisan, with outcomes (at all levels) publicly accessible. The commitment to public consultation prior to the development of recommendations to the Federal Government is welcome. Rigorous documentation of the processes used by the MBS Review Taskforce and evaluation once the MBS Review is completed will contribute to the transparency of the process.

Broader issues affect the operation of the MBS

The RACGP notes that issues with efficiency in health system funding can partially be attributed to the overlapping of public, private, state and federal funding responsibilities. This aspect, while being considered as part of the *Reform of the Federation*, contributes to the persistent inefficiencies in the healthcare system.

1.2 Additional issues

a) Should the role of the MBS be simply that of an administrative tool, or should it be used to actively guide quality medical practice?

The MBS needs to reflect high-quality, evidence-based care, not guide quality.

Items on the MBS should be evidence based, ensuring that they support the delivery of high-quality medical services. However, to an extent, the MBS currently limits high-quality medical practice as it does not fund all evidence-based services that health professionals need to provide patients.

For example, rebalancing the value of the rebate for the generation and review of GP Management Plans (GPMPs) might support quality practice by broadening the structured and proactive approach to monitoring and managing chronic diseases within general practice.

The management of complex multimorbidity (when there are several chronic diseases or where a patient has a mental health diagnosis with other chronic conditions) requires extensive time and skill from a GP. The current structure does not account for the time and flexibility needed to support high-quality care.

Ultimately, the MBS is an administrative mechanism and should not guide medical practice. Rather, it should reflect high-quality medical practice.

b) What can be done to reduce unexpected variation in the MBS items claimed for similar services?

It appears the MBS Review Taskforce's primary concern regarding unexpected variation relates to claims for surgical and procedural items. The RACGP could comment more specifically on this issue if the MBS Review Taskforce identified similar unexpected variation in MBS item claims for general practice patient services.

c) What implementation issues should be considered when amending or removing MBS items?

The implementation issues associated with amending or removing MBS items would vary according to the proposed amendment or removal. The MBS Review Taskforce should identify specific amendments or removals to enable the RACGP and similar organisations to provide informed comment on this topic.

Generally, a key consideration should be the likely administrative burden the amendment or removal of the item will place upon GPs and their practice staff (clinical

or administrative). Meeting the requirements of MBS items can significantly disrupt workflow, with little or no benefit resulting from the compliance burden.

It also subtracts from the time GPs can spend treating patients or improving the quality, safety, efficiency and cost-effectiveness of their services. Any amendments should aim to reduce administrative burden for GPs and their teams.

Communication strategies must openly and transparently communicate to stakeholders the MBS Review Taskforce's decisions regarding MBS changes before implementation. Health professionals must also be allowed sufficient time to understand and implement the changes within the practice setting.

Too many changes to the MBS in a short period would cause confusion for health professionals and patients. Therefore, the RACGP recommends a gradual and planned approach to the introduction, amendment or removal of MBS items.

d) Are there any other principles that must guide the Review?

Ensure appropriate indexation

Indexation of patient MBS rebates is inextricably linked to the MBS's capacity to function as a mechanism to support universal access, regardless of a person's financial circumstances. The MBS Review Taskforce must consider the ongoing indexation of the MBS rebates as an evidence-based mechanism to support access to care. Scheduled fees should keep pace with the costs of providing high-quality medical services. This would require indexation at a rate greater than in the traditional indexation measure (Wage Cost Index [WCI5]) applied prior to the commencement of the indexation freeze in 2015.

Parity for GPs

The skills, training, responsibility, practice costs and effort of GPs need to be valued equally with those of other medical specialties. Rebates across all medical specialties should be comparable regardless of specialty vocation. Adequately resourced, good quality care in general practice will improve cost-effectiveness and sustainability of the healthcare sector more broadly.

Prioritise delivery of care in primary healthcare settings

The MBS Review Taskforce should seek to support expansion of the range of services delivered in the primary healthcare sector. This would require MBS support for the devolution of all services that GPs and their teams can provide in general practice (particularly procedural services) from the hospital setting.

The patient rebate provided to support the delivery of a service in general practice that was previously delivered in another healthcare setting should remain the same despite the change in location – reflecting the value of the work provided as opposed to the setting.

2. Evaluating the MBS Review

2.1 Online questions

a) How can the impact of the MBS Review be measured?

The MBS Review Taskforce should make its determinations available to members of the public and health professionals to allow those not directly involved to understand its decisions and intent.

Ongoing change to medical and healthcare practice will make measurement of the impact of the MBS Review difficult. Surveying patients and health professionals may provide some perspective on the impact of the MBS Review.

Reductions in emergency department presentations, hospital admissions and readmissions could indicate that patients have access to evidence-based, high-quality care through a greater number of patients being managed effectively in the community.

Formal evaluation of the review process may also provide insight into its impact.

b) What metrics and measurement approaches should be used?

The RACGP considers identification of metrics and measurement of the impact of the MBS Review to be the purview of the MBS Review Taskforce.

c) How should we seek to improve this measurement and monitoring capability over time?

The RACGP considers the development and improvement of measurement and monitoring capability of the impact of the MBS Review to be the purview of the MBS Review Taskforce.

However, suggestions for the MBS Review Taskforce's consideration for improving measurement and monitoring capability over time include the standardisation of medical classifications, medical record formats between agencies and data collection specifications. Similarly, consulting and engaging with professional researchers in clinical practice would improve measurement and monitoring capability over time.

3. Need for evidence-based reviews

3.1 Online questions

a) Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part the Review as a priority?

The RACGP has identified none in general practice.

b) Which services funded through the MBS represent high-value patient care and appear to be underutilised?

Most consultations provided by GPs represent high-value patient care, higher than the MBS recognises and supports with patient rebates.

The following are examples of some high-value services that are underused.

Items 36 and 44 – Level C and D GP attendances

MBS items for professional GP attendances for consultations longer than 20 (Level C) or 40 (Level D) minutes are often used when patients have multiple, complex health issues to address. The value of the patient's rebate decreases significantly per minute the longer the consultation, meaning the rebate patients receive drops in relative value to that for shorter consultations (penalising patients who require longer consultations). This results in GPs underusing these items in comparison to other items (eg Level B GP attendances).

More support for longer consultations is required to allow patients and GPs to take the time needed to address the relevant issues, to undertake a range of preventive health activities and to fully establish a strong GP–patient relationship.

Items 4, 24, 37, 47 – Standard GP attendance at a hospital, institution or home

These items support access to GPs in places other than the GP's practice. They vastly undervalue the time and work involved in providing access to care for patients who are unable to attend a practice. These types of consultations also result in a significant and ongoing amount of additional work outside the consultation and, due to this work and travel time, can be very time-consuming. As a result, the number and range of GPs who provide home visits or visits to RACFs is declining, limiting access to care for these patients.

Item 35503 – Introduction of intrauterine contraceptive device

Long-acting, reliable forms of contraception such as intrauterine devices (IUDs) are an important addition to the available methods to prevent unwanted pregnancy and treat menorrhagia. Due to their long efficacy, IUDs save Medicare expenditure over time through fewer appointments and subsidised scripts for other contraceptives. However, many GPs decide not to learn the skills required to introduce IUDs because the MBS item for the service vastly undervalues the skill and time involved.

Additionally, GPs who do learn the skill of introducing IUDs face difficulty maintaining their skills because the service is underused in general practice due to insufficient support from the MBS. Often, this means GPs must instead refer patients to higher cost providers (eg gynaecologists and public hospital or family planning clinics) for the procedure to be performed because they have not maintained the required skill.

Items 2721, 2723, 2725, 2727 – Focused psychological strategies

GPs play a crucial role in providing mental health services to Australians. In a rural or remote area particularly, the GP may be the only health professional available to provide first contact for mental health presentations. Support for GPs to develop advanced mental health skills is limited, and there are many barriers preventing GPs from undertaking focused psychological strategies (FPS) skills training. However, once GPs are qualified to deliver advanced mental health services, the patient rebates do not provide adequate support to provide comprehensive consultations.

3.2 Additional issues

a) Should cognitive (clinical diagnostic) services receive priority attention?

Clinical diagnostic and procedural services deserve equal attention from the MBS Review Taskforce. GPs provide **whole-person care** and understand how biological, psychological and social factors contribute to health. Therefore, the priority should be to ensure that parity in support for clinical, diagnostic and procedural services is achieved.

The RACGP has consistently advocated for better recognition and support for cognitive, generalist medicine, in contrast to the current emphasis on procedural, highly specialised medicine. The MBS has historically weighted procedures over complex and skillful consultation-based management.

Better supporting cognitive, generalist medical services to achieve parity with procedural services is the required response to deal with the increasing complexity patients and health professionals face. Multimorbidity is common and increasingly the norm among general practice patients. This is particularly the case among disadvantaged populations, and rural and remote communities.

Patients who experience multimorbidity will require more healthcare resources over time. As generalists, with skills in diagnosis and complex care, GPs are best suited to working with patients with multimorbidity. These patients will need generalists with clinical diagnostic expertise to assist them to maintain and improve health, in addition to procedural and/or partialist care.

4. MBS legislation and 'rules'

4.1 Online questions

a) Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

Remove restrictions on the use of telehealth

The MBS Review Taskforce should make recommendations to remove the restrictions on electronic consultation and communication between patients and doctors to allow greater use of these methods. Restricting the use of these forms of communication limits patient access to care, particularly care that could be delivered more cost-effectively and efficiently. Removing these restrictions would be a large step toward modernising the MBS and recognising the changes in how care is being delivered now compared to when the MBS was first established.

Remove restriction on bulk billing and concurrent patient contribution

Under the *Health Insurance Act 1973* (the Act), GPs are unable to bulk bill for a service and additionally charge a patient contribution to cover the costs of consumables, record-keeping fees, booking fees, administration and registration. These restrictions prevent GPs charging for consumables and other basic overhead costs, affecting the viability of general practice when bulk billing – particularly for GPs working in rural, remote or lower socioeconomic areas.

Removing this restriction would allow GPs to charge a modest patient contribution for consumables and administration costs for those patients who can afford it.

Recognise GPs as specialists

GPs are recognised as specialists by the Medical Board of Australia (MBA); however, the Act does not classify GPs as specialists. These differences in law have inadvertently resulted in inconsistencies in the recognition of GPs as specialists, especially when GPs apply to be recognised as a specialist by government and statutory bodies. This contributes to a broader issue, whereby there are instances where government, other specialists and the public underestimate and misunderstand the full extent of GPs' clinical skills, therapeutic capacity and specialisation in generalism.

The MBS Review needs to acknowledge that these inconsistencies exist and have an impact on the recognition of GPs as specialists. The RACGP therefore recommends that the MBS Review Taskforce considers relevant MBS processes and the use of specialist terminology to ensure consistent recognition of GPs as specialists and accurate reflection of GPs' skills and therapeutic capacity.

b) Are there rules which apply to individual MBS items which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

Restriction on claims for chronic disease management and consultation items

The prohibition placed on patient claims for both general practice attendance items and Chronic Disease Management (CDM) items on the same day from the same GP ('same day billing') is detrimental to holistic, patient-centred care. The measure hinders GPs from providing acute care to a patient when they attend for a planned CDM consultation, or it means a GP must forfeit the opportunity to document a care plan or review when a patient presents with an unrelated acute condition.

Patients are more likely to forgo ongoing management of chronic conditions in order to afford care for acute concerns, exacerbating chronic conditions that could be effectively and efficiently managed in the general practice setting. Patients are also inconvenienced by having to make multiple visits to their GP.

Oddly, patients can claim rebates for a CDM item and a general consultation item on the same day as long as two different GPs provide the respective services. This restricts a patient's access to their preferred GP and hampers continuity of care by promoting fragmentation. Continuity of care, particularly with the same GP, leads to better health outcomes and less demand for more expensive hospital services.

Requirements for documentation of chronic disease management items

The paperwork required for the preparation and review of GPMPs and Team Care Arrangements (TCAs) is onerous, with 30 individual requirements for GPMPs and TCAs set out in the *Health Insurance (General Medical Services Tables) Regulations 2010.* The administrative burden of these items is unwarranted, inconsistent with the approach to all other MBS items and ultimately unnecessary. Many of the requirements describe aspects of routine, high-quality general practice care, such as gaining informed consent, taking sufficient notes and discussing treatment plans during consultations.

Broaden eligibility for health assessment items

Comprehensive health assessments result in better detection of health issues. The categories of people eligible for health assessment items (items 701, 703, 705, 707) should be amended to include children and young people in out-of-home care and young people requiring statutory supervision in the youth justice system, in recognition of the poorer health status of these people compared to their peers. Other Australian children and young people who are likely to have comparatively poorer health outcomes are entitled to these items (Aboriginal and Torres Strait Islander children, children with intellectual disabilities, and refugees and humanitarian entrants). Extending eligibility for the health assessment items to this group of children and young people would ensure consistency and improve access to care for this vulnerable group.

c) What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

Providing health professionals with greater access to consistent and timely advice from Medicare would vastly assist them to understand and apply rules and regulations correctly when MBS item descriptions are inadequate and ambiguous. This includes simplifying MBS Online.

The RACGP also recommends consideration of scenarios where a practitioner, in seeking advice from Medicare on the application of an MBS item, is advised that they must satisfy themselves that their peers would regard the provision of the MBS service as appropriate for that patient, given the patient's need and circumstances. In some instances, medical colleges have been expected to provide interpretation of Medicare rules or regulations to their members without the legal authority to assure members that Medicare will consider their use of MBS items appropriate, even if the profession does. Additionally, there are no criteria for satisfactorily establishing or documenting whether health professional peers consider a service appropriate for a patient.

To ensure Medicare providers have access to timely and accurate advice, the RACGP suggests the MBS Review Taskforce recommend review and improvement of provider enquiry line (Ask MBS) processes.

Related to this, when Medicare and/or the Department of Human Services identifies irregular or inappropriate billing, they should be more responsive and quickly address issues in an educative rather than punitive manner, clearly explaining what the issue is, and how it contravenes Medicare rules.

4.2 Additional issues

a) Are there existing rules which are causing unintended consequences or are outmoded and should be reviewed?

As identified earlier, the restriction on 'same day billing' of CDM and general consultation items should be reconsidered due to its impact on patient access to care from their usual GP.

b) Are there alternative solutions to deliver the original intent?

With regard to the restriction on 'same day billing' of CDM and general consultation items, the RACGP has previously discussed alternative methods to prevent the issues of inappropriate same day billing with the Department of Health. Removing the broad restriction that prevents patients from receiving ongoing care from their GP is possible through implementing targeted compliance measures to prevent inappropriate claims.

c) In amending any existing rule/s, are there any potential adverse impacts on consumers, providers or government?

There has been ongoing discussion in other forums about introducing referral arrangements for a broader range of primary healthcare professionals.

The RACGP also assumes many professional bodies will lobby the MBS Review Taskforce to recommend expanded referral arrangements subsidised by the MBS. Therefore, the RACGP strongly warns the MBS Review Taskforce against amending existing rules to broaden the range of providers who can initiate referrals.

As the specialists in primary healthcare, it is crucial that GPs remain the gatekeepers to the health system. There needs to be a centralised point in the primary healthcare system for managing requests for pathology and radiology and seeking specialist advice and care for patients. Otherwise, significant increases in cost are inevitable. Duplication of effort, or re-creating models of care in other settings, will result in increased fragmentation of care, leading to higher Medicare costs and worse health outcomes for patients.

Research on continuity of care shows that patient outcomes improve when patients have a strong ongoing relationship with a GP.[2–5]

d) Are there any new rules which should be introduced?

A patient's usual GP should be responsible for initiating and reviewing GPMPs, not 'any GP'. Yet, there is no provision to ensure that this occurs. The value and health outcomes of these items are the result of continuity of care and the ongoing relationship between the patient and their usual GP. The RACGP recommends high-value MBS items, such as the CDM items, be linked with a patient's usual practice in order to maximise the effectiveness of these items. A patient's 'usual practice' could be identified through a system of voluntary patient enrolment, as outlined in the RACGP's *Vision for general practice and a sustainable healthcare system.*

e) Are there medical services which should not be funded for reasons other than concerns about safety and/or clinical efficacy? How can these be defined unambiguously?

The RACGP has not identified any specific medical services within general practice that the MBS should not fund at this time.

However, we note there is a delicate balance between ensuring the services the MBS supports are evidence-based while not excluding support for newer treatments where evidence of efficacy is emerging. Relying on a large evidence base favours older treatments and practices. Additionally, a lack of evidence does not necessarily mean a lack of benefit.

Increasing support for GPs to conduct research within general practice would lead to better diffusion of innovative treatments and practices, while allowing a local and contextualised evidence base to be established.

5. Access to MBS data

5.1 Online questions

a) What kind of information do consumers need to better participate in decisions about their health care?

Patients need accessible information from a range of sources to better participate in decisions about their healthcare. Chiefly, patients need a better understanding of Medicare (as a public health insurance scheme). This includes understanding the value and purpose of MBS rebates. Our members often comment that patients do not understand that the MBS provides a rebate to assist them to meet the cost of healthcare rather than a payment for their GP.

Open discussion between health professionals and patients about costs is needed. For example, the potential costs (financial, time and emotional) of commencing a course of treatment compared to non-intervention or observation would assist patients when making healthcare decisions.

Patient education on what high-quality healthcare should look like, and what to expect from their healthcare providers and planned treatment or investigation, would also empower patients to determine value and better participate in decisions.

Due partially to language issues, patients from non–English-speaking backgrounds often have difficulty accessing GP services. This is a particularly heightened problem for patients who have arrived as refugees and have complex medical problems. Consistent use of well-trained interpreters during consultations assists patients from non–English-speaking backgrounds to better receive information and participate in decisions about their healthcare. Greater support is needed from the MBS for the use of interpreters when patients access MBS services to ensure the service is valuable and useful to the patient.

5.2 Additional issues

a) Should the MBS be used to encourage more systematic collection of data?

The RACGP could provide informed comment on this question if specific examples were provided of what the MBS Review Taskforce envisages would be the intent and uses of such data.

Broadly, the information collected now by Medicare in administering the MBS does not appear to be well used and is not readily available for analysis. Collecting additional data does not offer much value to health professionals when delivering care to their patients, particularly given that the current data collected is not well used.

Increased data collection is also likely to result in greater administrative burden for clinical and administrative staff.

b) Are there MBS items which could have health outcomes data readily linked to the provision of health care?

Making healthcare providers accountable for their patients' health outcomes is problematic at best.

Health providers cannot be held accountable for patients' health outcomes due the social determinants of health. These are out of health professionals' control, and affect and influence patients' health outcomes (ie housing, education, socioeconomic status, and rurality). Penalising health professionals for poor health outcomes related to issues that are entirely out of their control would not build trust or goodwill, and will potentially result in disadvantaged patients being denied access to care, as health professionals may seek to avoid taking responsibility for these patients.

Efforts to implement health outcomes reporting are likely to have the opposite of the intended effect, creating more red tape, reducing doctor–patient time and increasing issues related to the maldistribution of workforce and patient access to care – particularly for rural, remote, Aboriginal and Torres Strait Islander, and lower socioeconomic patients.

There is no evidence to suggest that reporting health outcomes improves the quality or safety of care, and there are not successful overseas models that we can adopt.

Any system that reports on patient health outcomes must not be used as a mechanism to reward or penalise individual GPs or general practices.

c) Should MBS items support participation in the creation or development of other data sources? For example, myHealth Record, clinical trials, funding linked to evidence production.

There are many unresolved challenges facing the use of myHealth Record, and incentives or support payments will not promote adoption of myHealth Record while the current usability issues remain unaddressed. Meaningful engagement between the Federal Government and the healthcare sector is needed to address these issues and for myHealth Record to be successfully adopted. This should occur prior to consideration of linking MBS items to creation or development of myHealth Record as a data source or introducing MBS items numbers to support uploading of patient information.

In order to increase system uptake, GPs need to be provided with a clear myHealth Record value proposition in terms of deliverables, including clinical benefits and costs. Significant work is also required to integrate the creation and updating of a shared health summary into established clinical workflows.

Meaningful use of myHealth Record relates to safety, quality, communication and healthcare outcomes – not data collection. Characterising myHealth Record as a data source rather than a tool to support clinical practice is of concern to GPs, who will be the primary users of the system and who will be primarily affected by MBS items linked to myHealth Record participation, creation or development.

6. Introduction and amendment of items to support existing service delivery

The consultation paper discusses the MBS Review Taskforce's capacity to recommend change to existing items, or the introduction of new items, where they relate to existing MBS services. While there is scope for a number of MBS item amendments and additions relating to general practice services, the RACGP suggests the MBS Review Taskforce considers the following suggestions as priorities for general practice.

Telehealth

The RACGP recommends amendment of the descriptors for GP consultations to support telehealth consultations. This would improve access to care for patients in rural and remote areas, for people with limited mobility or for people with limited access to transport. Providing 75% of the scheduled patient rebate for these consultations would expand access to GP services.

Removing the 15 km minimum distance requirement for GP, patient and specialist telehealth consultations would also remove current access barriers.

Coordination of care item

The RACGP's *Vision for general practice and a sustainable healthcare system* recommends amending the general practice CDM items to better target services to patients most in need. A three-tier system to support working with patients with varied needs, with the degree of service escalating according to need, would enhance the general practice response to increasing patient complexity. While originally conceived as support payments similar to those provided through the Practice Incentives Program (PIP), coordination of care MBS items could be introduced. These would recognise the work GPs and their teams currently undertake to coordinate care for their patients outside of their regular face-to-face consultations.

Preventive health

The focus in the MBS on supporting preventive health is minimal, despite the expansion of the general practice attendance item descriptors (to include providing appropriate preventive healthcare) in 2010.

The RACGP's *Guidelines for preventive activities in general practice,* 8th edn ('Red book') provides a practical framework that supports GPs to provide preventive services to their patient population. The RACGP recommends that the MBS Review Taskforce consider options for the MBS to better support preventive healthcare, guided by the recommendations for preventive care made in the Red book, through, for example, the expansion of eligible patient groups for GP Health Assessment MBS items.

Point-of-care testing

Point-of-care testing (PoCT) – pathology testing performed by, or on the behalf of, a medical practitioner at the time of consultation – facilitates immediate and informed decisions about patient care. While off-site pathology laboratories have traditionally performed testing, unnecessary time delays in diagnosis, care planning and ongoing management occur because of these processes. Including support in the MBS for general practice-based PoCT would vastly increase convenience for patients and enhance a GP's capacity to ensure effective clinical management and improved health outcomes.

GP Mental Health Treatment Plans

The RACGP believes changes can be implemented to improve the structure of the MBS item numbers relating to GP Mental Health Treatment Plans (2715, 2717) to better support the varying needs of patients with (often multiple) complex conditions. Changes to these MBS items are needed to facilitate a thorough assessment of patient needs and to ensure that the identified level of need is matched with appropriate and cost-effective interventions with respect to **both** the mental and physical health needs of patients.

A restructure of the mental health item numbers should better delineate between the phases of care required, including assessment of patient complexity followed by management planning and risk stratification, with the ultimate aim of improving patient outcomes. Structural changes should allow mental health items to:

- foster a stepped-care approach to mental healthcare (where appropriate)
- improve integration of mental health item numbers with the chronic disease management plan item numbers (so that patients with multimorbidity receive well-coordinated, seamless care that meets both their physical and mental healthcare needs)
- retain incentives that promote timely follow-up and proactive review of all treatment/management plans for patients with mental health needs and/or chronic physical health concerns.

References

1. Department of Health. Annual Medicare statistics. Canberra: DoH, 2014. Available at www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics [Accessed 30 October 2015].
2. Gunther S, Taub N, Rogers S, Baker R. What aspects of primary care predict emergency admission rates? A cross sectional study. BMC Health Serv Res 2013;13:11.
3. Huntley A, Lasserson D, Wye L, et al. Which features of primary care affect unscheduled secondary care use? A systematic review. BMJ Open 2014;4(5):e004746.
4. Lin IP, Wu SC, Huang ST. Continuity of care and avoidable hospitalizations for chronic obstructive pulmonary disease (COPD). J Am Board Fam Med 2015;28(2):222–30.
5. Menec VH, Sirski M, Attawar D, Katz A. Does continuity of care with a family physician reduce hospitalizations among older adults? J Health Serv Res Policy 2006;11(4):196–201.