RACGP

Royal Australian College *of* General Practitioners

RACGP Submission:

Report from the Specialist and Consultant Physician Clinical Committee

July 2019

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1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Specialist and Consultant Physician Clinical Committee (the Committee) for the opportunity to provide feedback on its report.

The RACGP is Australia's largest general practice professional body representing over 40,000 members working in or towards a career as a specialist general practitioner (GP).

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for training
- maintaining the standards for quality general practice
- supporting specialist GPs in their pursuit of excellence in patient and community service.

2. Summary and recommendations

The RACGP supports the Committee's recommendations to:

- introduce time-tiered attendance items to replace the current initial and subsequent attendance items for non-GP medical specialists and consultant physicians
- encourage the involvement of a patient's usual GP (or delegate) in case conferences as a measure to support continuity and coordination of care
- retain the specialist to specialist referral validity period at three months as opposed to increasing it to six months.

The RACGP recommends that the Committee:

- work with the Principles and Rules Committee to establish referral rules for a single course of treatment
- propose that the methodology for calculating rebate values is applied consistently across all time-tiered rebates to address the value disparity between GP and non-GP specialist items
- consider the RACGP's response to the General Practice and Primary Care Clinical Committee's report when developing its final recommendations.
- suggest the category 'specialist' is renamed to appropriately recognise that GPs and consultant physicians are also medical specialists
- encourage robust and regular monitoring of the use of the nine telehealth loading items during their staged removal to ensure that patient access to services is not compromised
- further simplify specialist and consultant physician case conference items by mirroring the structure that currently exists in general practice.

3. Rationale

3.1 Introduce time-tiered attendance items (Recommendation 1)

The RACGP supports the recommendation to introduce time-tiered attendance items to replace the current initial and subsequent attendance items for non-GP medical specialists and consultant physicians.

3.1.1 Impact on coordination of patient care

Introducing time-tiered attendance items (and removal of initial and subsequent attendances) will improve problems experienced by GPs and their patients regarding honoring referrals.

Many of our members report that patients are often unnecessarily asked by a specialist or consultant physician to return to their GP to seek another referral.

The significantly higher value of the initial attendance item, coupled with Medicare's contradictory definition of when an initial consultation can be claimed, is likely to be encouraging this practice given that:

- there is a significant difference between the rebate value for an initial versus a subsequent attendance by a specialist or consultant physician, and this fee difference appears to encourage requests for additional referrals for the same condition
- Medicare's definition of a single course of treatment can be misinterpreted (the RACGP has previously highlighted this to the MBS Review Taskforce).

  While the definition states that an initial attendance can only be claimed once for a single course of treatment, it also highlights that in limited circumstances, '*the attendance following the new referral initiates a new course of treatment for which the Medicare benefit would be payable at the initial consultation rates.'* This line is often perceived by specialists and consultant physicians as allowing more than one initial attendance to be billed for the same health condition.

The Committee's recommendation to introduce time-tiered attendances will remove the current initial and subsequent attendance structure, and therefore remove the financial incentive to seek a new referral. This will go some way to addressing unnecessary referral requests in general practice resulting in more appropriate and efficient use of Medicare funding and patient/clinician time and resources.

In their 2016 report the Principles and Rules Committee addressed Medicare's contradictory definition by recommending (issue 3) that:

> *'only one initial attendance item be claimed in relation to any single course of treatment for a particular patient, regardless of the duration of that course of treatment. All other attendances are to be considered subsequent attendances.'*

The RACGP supported this recommendation. However, if recommendation 1 from the Specialist and Consultant Physician Clinical Committee is accepted by government, the Principles and Rules Committee's recommendation that 'only one initial attendance be claimed' and 'all other attendance are to be considered subsequent attendances', will no longer be relevant.

In light of the removal of the initial and subsequent attendance structure, the RACGP recommends that the Committee work with the Principles and Rules Committee to review the underlying issue concerning referral validity for a single course of treatment.

The issue of unnecessary requests for referrals will be resolved to some extent by the removal of the current initial and subsequent attendance structure. However, regardless of whether specialists have initial, subsequent or time-tiered attendances, referral validity rules must be clarified in order to minimise unnecessary referrals. The RACGP recommends that the Committee refer this issue to the Principles and Rules Committee for their consideration.

3.1.2 Duration of time-tiered items

The RACGP recommends that the duration of the time-tiered items should be consistent with general practice time-tiered items (Table 1).

Table 1. Current time-tiered structure of standard GP professional attendances, in consulting room:

MBS item number	Service	Duration
3	Level A attendance	Obvious and straightforward cases
23	Level B attendance	Less than 20 minutes
36	Level C attendance	Lasting at least 20 minutes
44	Level D attendance	Lasting at least 40 minutes

The report recommends that the specialist and consultant physician time-tiers are the same as those recommended for general practice by the General Practice and Primary Care Clinical Committee (Recommendations 14 and 15).

The RACGP supports the alignment of specialist and consultation physician time-tiers with those currently in general practice.

The RACGP did not support the changes to time-tiers proposed in the General Practice and Primary Care Clinical Committee's report to:

- introduce a 6 minute minimum time for a Level B professional attendances (items 23, 24, 35, 5020 and 5023) consultation item
- introduce a new Level E consultation item at 60 minutes or more.

Level B consultations are currently time and content based. In most circumstances, a consultation that meets the requirement of the Level B descriptor will be more than 6 minutes in length. However there are circumstances where the requirements for a level B consultation are met in less than 6 minutes. For example, an experienced GP can efficiently and effectively see a patient with a viral upper respiratory tract infection – examine their ear, nose and throat, measure their blood pressure and discuss preventive health – in under 6 minutes. Enforcing a minimum time will act as a disincentive for efficient practice, and patients receiving these efficient services will effectively have their patient rebate cut.

The Specialist and Consultant Physician Clinical Committee notes that minimum times should not be applied to specialist and consultant physician time-tiers for the reasons identified. This recognition of the issues associated with imposing a minimum time on consultations must be considered across all professional attendances, not just those undertaken by specialist and consultant physicians.

The RACGP supported the intent of introducing a Level E (more than 60 minutes) attendance in general practice. However, introducing a level E rebate alone, without reconsideration of rebate values or intervals, will only exacerbate current problems with the diminishing value of rebates in the longer time-tiers.

The Specialist and Consultant Physician Clinical Committee should consider sections 3.10 and 3.11, in relation to recommendations 14 and 15 in the RACGP's response to the General Practice and Primary Care Clinical Committee's report when developing its final recommendations.

3.1.3 Disparity between GP and other medical specialist value in the MBS

The RACGP recommends that the disparity between the value of GP and other medical specialist items is addressed as a priority.

Currently, consultation items for other medical specialists are valued much higher than GP consultation items. GP professional attendances items are valued at least 18.5% less on average than professional attendance items for specialist and consultant physicians, even after consideration of longer training time. While a GP 15 minute consultation is valued at $37.60 under the MBS, an initial specialist or consultant physician consultation of 15 minutes is valued at $86.85.

The Committee does not suggest fees for the new time-tiers and notes that the methodology for calculating schedule fees for attendance items is outside of its scope. Once a methodology for calculating fees has been determined, and appropriately consulted on, the same methodology must be applied to both specialist and consultant physician as well as general practice attendance items. This will ensure transparency in MBS rebates and remove disparities in the value of rebates between medical specialists.

3.2 The distinction between 'specialists' and other medical professionals in the MBS

The Report touches on the distinction between specialists and consultant physicians in the MBS, noting that this distinction is based on the traditional roles and training pathways of these groups.

GPs are medical specialists, as recognised under the Health Practitioner Regulation National Law Act 2009, and the term 'specialist general practitioner' is a protected title.

Like all other medical specialists, GPs undergo significant training in medicine, including the completion of five to six years of a Bachelor Medicine and Bachelor of Surgery (MBBS), followed by two years of post-graduate hospital training and successful completion of a GP training program through a specialist medical college (RACGP or Australian College of Rural and Remote Medicine). Despite this, GPs are not recognised as 'specialists' in the MBS.

Applying the term 'specialist' to only limited medical specialists can blur interpretation of the MBS. It is likely also contributing to the undervalued role of GPs within the MBS and the perception that GPs are not specialists.

The RACGP recommends that another title is used to describe the group of medical specialists currently called 'specialists' within the MBS. A more appropriate title might be 'consultant' however, consultation with the broader profession is required before finalising this.

3.3 A new framework for telehealth (Recommendation 7)

RACGP members have raised concerns regarding the recommendation to remove the nine telehealth loading items. Removal of the incentives could lead to a reduction in the number of non-GP specialists providing telehealth services, possibly reducing access for patients.

This is particularly an issue in rural or remote areas, where patients already face difficulties when accessing care by other medical specialists.

The Committee has proposed to incrementally reduce the derived loading fee and to monitor this change to ensure that it does not result in unwanted consequences. The RACGP agrees with this approach and the intent of the recommendation to ensure that Medicare is not overfunding these services unnecessarily.

To ensure no adverse effects on patient access to specialist services, the RACGP recommends that robust and regular monitoring of the use of these items is undertaken during their staged removal. If data or reports from patients or their GP indicate that access has been compromised, the gradual removal of the incentives should cease until the issue has been further investigated and resolved.

3.4 Introduce a new framework of case conference items and allow access to all consultant specialists (Recommendation 9)

3.4.1 Consistency across the MBS

One of the key objectives of the MBS Review is to simplify the frameworks under which care is provided to patients. The report proposes introducing a new framework for case conference items that features the following three different types or categories:

- discharge planning case conferences
- community case conferences
- treatment planning case conferences.

While introducing this new framework simplifies the current very complex specialist and consultant physician case conferencing structure, the RACGP recommends this could be simplified further by mirroring the case conferencing structure of general practice items.

General practice has one set of case conferencing items that apply to various ‘types’ of case conferences, including community based and discharge case conferences. The case conference items relate to either ‘organising and coordinating’ or ‘participating’ in a case conference and are split into time-tiers depending on length of case conference.

3.4.2 GP involvement in case conferencing

Recommendation 9 also proposes to update the explanatory notes for case conference items to encourage GP participation by mandating it. This recommendation is overly simplistic and fails to recognise the logistical issues with conducting case conferences. Case conferences are extremely difficulty to organise and execute. Attempting to secure time in the schedules of multiple busy clinicians is very difficult, and due to the nature of medicine, clinicians are often late or unable to attend the case conference on short notice due to other medical emergencies.

However, the intention to develop better mechanisms within the MBS to support continuity of care is supported and welcomed. The RACGP recommends that the explanatory note should state that where feasible, a patient’s GP or delegate should attend a case conference. Where it is not feasible for a GP to attend, GPs should be supported to review the case conference report and discuss the report with the patient and/or the health professionals involved. A new case conference item number should be implemented to support this aspect of care.

3.5 Recommendation 18 – Retain the current specialist to specialist referral validity period (Recommendation 18)

The RACGP supports the recommendation to retain the specialist to specialist referral validity period of three months as opposed to increasing it to six months. Longer term management of patients is best coordinated by their usual GP and specialist to specialist referral should only be a short-term arrangement.

3.6 Across all recommendations

3.6.1 Reinvesting savings into Medicare

The government has committed to reinvesting MBS Review savings back into Medicare. The RACGP calls on the MBS Review Taskforce to provide more transparency regarding this reinvestment by detailing the savings that will be made, and the additional spending that will be required, to any recommendations it makes to the government.

The RACGP would also like to see, in detail, how the MBS Review savings have been, or will be, reinvested into the health system, particularly into general practice.

While making improvements to the MBS are essential, this alone will not be enough to ensure a sustainable health system in the long term.

3.6.2 Redesigning government support for patient access to general practice

The way in which the government supports patients to access general practice services requires a comprehensive redesign. GPs and practices receive minimal or no support for providing essential aspects of patient care, such as:

- continuity of care – formalising relationships between patients and their GP
- health service coordination – improving coordination between various levels of the health and social systems
- comprehensiveness of care – supporting patients to access the range of services they require
- team-based care – ensuring patients are benefiting from access to a multidisciplinary healthcare team.

The RACGP's Vision for general practice and a sustainable healthcare system (the Vision) offers a framework for redesigning government support for excellence in healthcare. It provides the solution to addressing a range of issues and pressures currently facing general practice and the Australian healthcare system more broadly. The Vision demonstrates how well-supported GP teams can deliver sustainable, equitable and high-value healthcare, benefiting patients, providers and funders. It is a document that must be considered when making any improvements to the MBS or primary care that affects GPs and their teams.

The RACGP notes the recent decision for the MBS Review to conclude by mid-2019, despite commitment in the 2017-18 Federal Budget to fund the review until at least 2020. The RACGP recommends that any changes made as a result of the MBS Review be subject to rigorous monitoring, evaluation, and consultation with stakeholders, to ensure that the intended results are being achieved.

3.7 Further discussion

If you have any questions or comments regarding the RACGP's submission, please contact myself or Ms Susan Wall, Program Manager – Funding and Health System Reform, on (03) 8699 0574 or at susan.wall@racgp.org.au