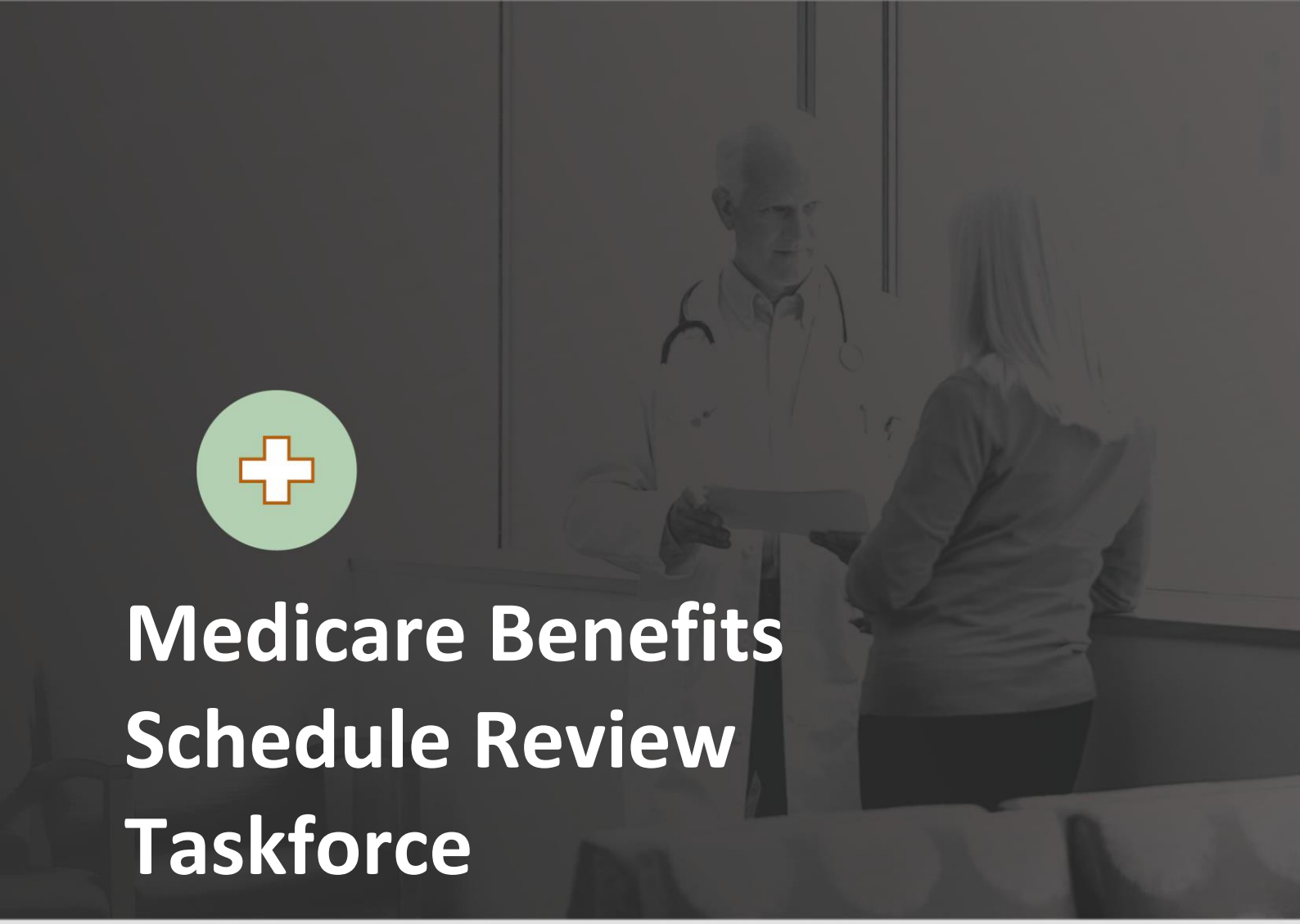

Medicare Benefits Schedule Review Taskforce

Report on Primary Care

June 2020

IMPORTANT NOTES

1. This report does not constitute the final position on these items, which is subject to:
   - Consideration by the Minister for Health, and
   - the Government.
2. The views and recommendations in this report originated from the relevant clinical committee or reference group. Following consultation with stakeholders, the clinical committee made amendments and presented this report to the MBS Review Taskforce for its consideration.
3. Any eliminations, amendments or commentary from the MBS Review Taskforce are noted in boxed comments in the body of the report:

> **[Group] Recommendation [#] – Taskforce's Advice**
>
> [The Taskforce's rationale behind the decision.]

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1 Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is reviewing how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce also seeks to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on four key goals:

1. Affordable and universal access
2. Best practice health services
3. Value for the individual patient
4. Value for the health system

The Taskforce endorses a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

1.1 General Practice and Primary Care Clinical Committee

The General Practice and Primary Care Clinical Committee (GPPCCC) was established in October 2016 to make recommendations to the Taskforce on the review of MBS items in its area of responsibility, based on rapid evidence review and clinical expertise. The group consisted of 21 members and undertook work across two phases. Details of the GPPCCC's membership are at Appendix A.

During Phase 1 (October 2016 – April 2017), the GPPCCC reviewed 111 items including rendered services (e.g. acupuncture, telehealth, assistance at operations, wound repair), referred services (e.g. secondary or tertiary care services, such as consultant physician attendances) and requested services by general practitioners (GPs) (e.g. diagnostic imaging and pathology services).

The Phase 1 interim report outlined the GPPCCC's recommendations regarding mechanisms that could support GP stewardship, MBS items covering services referred and requested by GPs, and an initial set of MBS items covering services rendered by GPs.

Draft Phase 1 recommendations were informed by targeted consultations with key stakeholders in early 2017. Given the significant intersects, the Taskforce agreed that the draft Phase 1 report would not be released for public consultation until Phase 2 work was completed.

During Phase 2 (February 2018 – July 2018), the GPPCCC reviewed 60 items including general consultations, chronic disease management, health assessments, and medication management.

1.2 Primary Care Reference Groups

During the second phase of the GPPCCC, the Taskforce also established five Primary Care Reference Groups (PCRGs) to focus on items that are primarily or exclusively provided by non-doctor health professionals and have a close relationship to primary care.

1.2.1 Aboriginal and Torres Strait Islander Health Reference Group

The Aboriginal and Torres Strait Islander Health Reference Group (the Reference Group) consisted of 12 members, including senior clinicians providing services to Aboriginal and Torres Strait Islander peoples',

health policy academics and consumer representatives. The Reference Group was tasked with providing advice to the Taskforce on 21 MBS items. Details of the Reference Group's membership are at Appendix A.

1.2.2 Allied Health Reference Group

The Allied Health Reference Group (AHRG) consisted of 18 members, including registered nurses, occupational therapists, dieticians, physiotherapists, audiologists and pharmacists. The AHRG was tasked with providing advice to the Taskforce on 26 MBS items. Details of the AHRG's membership are at Appendix A.

1.2.3 Mental Health Reference Group

The Mental Health Reference Group (MHRG) consisted of 21 members including registered and clinical psychologists, occupational therapists and social workers. The MHRG was tasked with providing advice to the Taskforce on 47 MBS items. Details of the MHRG's membership are at Appendix A.

1.2.4 Nurse Practitioner Reference Group

The Nurse Practitioner Reference Group (NPRG) consisted of 13 members including nurse practitioners, registered nurses and consumer representatives. The NPRG was tasked with providing advice to the Taskforce on 10 MBS items. Details of the NPRG's membership are at Appendix A.

1.2.5 Participating Midwives Reference Group

The Participating Midwives Reference Group (PMRG) consisted of 13 members including midwives, a GP and consumer representatives. The PMRG was tasked with providing advice to the Taskforce on 12 MBS items. Details of the PMRG's membership are at Appendix A.

The PCRGs are similar to the clinical committees established under the MBS Review. Each PCRG reviewed in-scope items, with a focus on ensuring that individual items and usage meet the four goals of the Taskforce. They also considered longer-term recommendations related to broader issues (not necessarily within the current scope of the MBS) and provided input to clinical committees, including the GPPCCC. Each PCRG has made recommendations to the Taskforce, as well as to other committees, based on clinical expertise, data, and evidence.

The PCRGs are unique within the MBS Review for several reasons:

- **Membership:** Similar to clinical committees, the PCRGs include a diverse set of stakeholders, as well as an ex-officio member from the MBS Review Taskforce. As the PCRGs focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care, membership includes many non-doctor health professionals, as well as an ex-officio member from the GPPCCC. Each PCRG also includes a GP, a nurse, and two consumer representatives.
- **Connection to the GPPCCC:** As part of their mandate from the Taskforce, the PCRGs were tasked with responding to issues referred by the GPPCCC. The PCRGs also reviewed some items delivered by GPs and proposed recommendations with implications for GP care. The GPPCCC ex-officio member on each PCRG helped to strengthen the connection between the two bodies and supported communication of the PCRGs' responses to the GPPCCC.
- **Newer items:** The items reviewed by the PCRGs have a shorter history than other items within the MBS; many were introduced only in the last decade. While this means that there is less historical data

to draw on, it also means that there are fewer items under consideration that are no longer relevant, or that no longer promote best-practice interventions, compared to other committees.

- **Growth recommendations:** Several of the PCRGs' in-scope items have seen significant growth since their introduction, often with the potential to alleviate cost pressures on other areas of the MBS or the health system, or to increase access in low-access areas. As a result, many recommendations focus on adjusting items that are already working well, or recommending expansion of recently introduced items to facilitate access to evolving models of health care delivery.

1.2.6 Scope of the Primary Care Reference Groups

All MBS items will be reviewed during the course of the MBS Review. Given the breadth of the review, and its timeframe, each clinical committee and PCRG developed a work plan and assigned priorities, keeping in mind the objectives of the review.

The PCRG review model approved by the Taskforce required the PCRGs to undertake three areas of work, prioritised into two groups.

Priority 1 - Review referred key questions on draft recommendations from the GPPCCC and develop recommendations on referred in-scope MBS items.

As part of this work, the PCRGs also reviewed and developed recommendations on referred issues from other committees or stakeholders where relevant.

Priority 2 - Explore long-term recommendations.

These included recommendations related to other MBS items beyond the PCRGs' areas of responsibility, recommendations outside the scope of existing MBS items, and recommendations outside the scope of the MBS, including recommendations related to non-fee-for-service approaches to health care.

1.3 Reports from the GPPCCC and PCRGs

Following a consultation period over the first half of 2019, the GPPCCC and PCRGs met to consider feedback received from stakeholders. The groups submitted their Final Reports to the Taskforce for consideration in August 2019.

During the Taskforce's deliberations on the reports, it quickly became apparent there was significant overlap across the recommendations. The Taskforce discussed the recommendations on multiple occasions over the remainder of 2019 and agreed to undertake further work to ensure a consistent view of primary care was presented to the Government. This work was undertaken in early 2020 and involved assessing each recommendation individually and as part of a theme group (see section on Key Themes) so as not to create inconsistency, fragmentation of care for patients or any unintended consequences.

Collectively, 101 recommendations were considered by the Taskforce in developing this consolidated report to provide its final advice on primary care related services.

The Taskforce's findings and advice on recommendations from the GPPCCC and PCRGs can be found with the reports below.

2 Primary Care in the MBS

Medicare is Australia's universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- free public hospital services for public patients,
- subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS), and
- subsidised health professional services listed on the MBS.

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

Primary care is generally the first point of contact people have with the health system. It relates to the treatment of non-admitted patients in the community and can include general practice, allied health services, community health and community pharmacy.

The types of services delivered under primary health care are broad ranging and include:

- health promotion,
- prevention and screening,
- early intervention,
- treatment, and
- management.

Primary care MBS items include a range of services provided by GPs, allied health providers, mental health professionals, nurse practitioners, practice nurses and midwives.

3 The Taskforce's approach to assessing primary care

3.1 Key themes

During their considerations of the GPPCCC and PCRG reports, the Taskforce noted significant overlaps and different levels of evidence for similar recommendations across the primary care reports. In some cases, the reports present different perspectives and views regarding similar issues.

The Taskforce established a Primary Care Working Group (the Working Group) consisting of 10 Taskforce members who undertook further work to ensure any endorsed recommendations had strong supporting evidence and a clinical basis behind them.

In late 2019, the Working Group thoroughly reviewed the 101 primary care recommendations and identified 60 as having potential overlaps. The Working Group's advice was provided to the Taskforce at their December 2019 meeting to assist in finalising its primary care recommendations to the Government.

This advice identified five key themes recurrent across the primary care recommendations requiring overarching consideration by the Taskforce:

1. **Alternative Funding Models and Pathways** – funding models outside the MBS, where a fee-for-service model may not be the best way to support patient care.
2. **Care Pathways** – patient care pathways and supporting integration of health professionals across the sector (for example, models of collaboration between providers).
3. **Research and Evaluation** – where further research and evidence gathering would help inform best practice care and investment.
4. **Scope of Practice** – defining the credentialing and scope of practice for different health professionals and their contribution to primary care.
5. **Telehealth** – using telehealth services to support / enable established models of care.

The Working Group offered guidance on a consistent approach to endorsing and/or making recommendations regarding primary care in the MBS, avoiding fragmentation of care while achieving best patient outcomes.

Note: Recommendations relating to telehealth are addressed in 'Other considerations'.

3.2 Thematic considerations

The following was considered in the Taskforce's assessment of the primary care recommendations:

3.2.1 Alternative Funding Models and Pathways

- The limitations of fee for service models – longitudinal care, patient complexity, the inflexibility of eligibility criteria and patient variability, the promotion of quantity versus quality, and preventative treatments for chronic and complex.
- Existing funding models – when considering the limitations of fee for service, existing alternative payment models complementary to the MBS include Health Care Homes (HCH) (especially in the context of chronic disease and allied health visits and patient stratification), Voluntary Patient Enrolment (VPE) (supports patient choice), Primary Health Networks (PHNs) (local need), and Practice Incentive Payments (PIP) (workforce support).

- Validity of proposal – when recommending alternative funding models, the validity of the proposal needs to be carefully considered. For example, the GPPCCC VPE recommendation rationale is evidence based, outcome based, addresses need and supports holistic care through GP stewardship.
- Some reasons a recommendation may be considered out of scope for inclusion in the MBS:
    - Is it currently not part of the MBS?
    - Is it a non-clinical service?
    - Is the service delivered elsewhere? For example, via the hospital system.
    - Is there an obvious non MBS solution?

Other considerations:

- Is the MBS the only way to address this need?
- Is the MBS the best way to address this need?
- Would implementation of this recommendation build inefficiencies into the system?
- Would this promote an MBS 'incentive' model?
- Would this underpin a successful private business model?
- Could this result in cost shifting?

3.2.2 Care Pathways

The following was considered in the Taskforce's assessment of the primary care recommendations:

- Patient Needs
    - The importance of allowing flexibility (noting a GP may not always be available or be the appropriate clinician).
    - Recognising the impact on patients. Will this streamline the process and enable better access for patients, without imposing a burden on GPs or the patient?
- GP Stewardship:
    - The importance of GP stewardship, particularly in the context of coordination of multidisciplinary (including specialist) care and protecting the patient from fragmentation of care.
        - Could this be adopted in very defined and clear cases?
            - If the patient lives in a remote community serviced by a fly-in fly-out GP?
            - In a rural setting, where the GP workforce may be transient, it may be that stewardship of care is maintained in the general practice, rather than with an individual GP.
            - Could an appropriately trained registered nurse or nurse practitioner, working within their scope of practice be appropriate to perform the stewardship role in certain circumstances?
            - In the case of chronic disease, could the HCH model be applied?
            - Can VPE arrangements be applied to practices as well as practitioners in certain circumstances?

- Can the My Health Record help facilitate GP stewardship?

Other considerations:

- Does this align with current guidelines and/or legislation?
- Will this maintain or promote continuity of care across the MBS and the broader healthcare system?

3.2.3 Research and Evaluation

The following was considered in the Taskforce's assessment of the primary care recommendations:

- Variability of evidence:
  - What is the level of evidence available? Does the evidence suggest there is a patient-level need or professional need?
  - Does the evidence suggest there is a gap in service provision? If so, does the evidence support inclusion in the MBS?
  - Is the evidence outcome-based?
  - If there is no evidence available with the recommendation, does this absence of evidence actually support the need for a research proposal?
- MBS:
  - Is the MBS the right model for this?
  - Does the evidence inform disinvestment and/or reinvestment of MBS funding?
- Medical Services Advisory Committee (MSAC):
  - Is there enough evidence to recommend to MSAC in the future?
  - Will this align with MSAC principles?

Other considerations:

- Does this proposal underpin a forward research agenda?

3.2.4 Scope of Practice

The following was considered in the Taskforce's assessment of the primary care recommendations:

- The MBS is a funding mechanism, and must not determine a providers scope of practice
- Defining scope of practice and distinguishing it from credentialing
  - How can both credentialing and scope of practice be clearly defined and determined across a range of health professions?
  - How can the credentialing of professional groups be clearly defined and determined?
  - How can scope of practice be clearly defined and determined in an out of hospital setting?
  - How can the difference between defining credentials and scope of practice be clarified in out of hospital settings?

  - Will the health professional be undertaking clinical services within their current contemporary scope of practice?
  - Does the clinical setting in which the services will be delivered have appropriate policy, quality and risk management assessment frameworks, staffing levels and health professionals to support the services?
  - Does the health professional undertaking the services comply with any Commonwealth and/or state legislation and are they supported by professional standards and evidence?
  - Is there a defined clear level of accountability? (licencing and liability)
  - Has an interdisciplinary professional consensus been explored or achieved?
- Supporting scope of practice
  - Processes to be put in place to ensure appropriate credentialing and scope of practice supports patient safety.
  - Can scope of practice for a range of healthcare professionals be determined without a Collaborative Arrangement?
  - How does scope of practice support team based care, safety and quality, informed consent and subsidiarity?

Other considerations:

- Appropriate credentialing and scope of practice supports safety and quality of services.
- What are the implications for patient outcomes and continuity of care?
- Is the health professional trained for this service?
- What is the accepted standard of credentialing to align with the scope of practice of this person/place?
- What does “qualified” actually mean? What are the credentialing requirements?
- How does/will the wider profession know that the healthcare professional is trained/qualified for this service?
- How will informed consumer choice and consent processes be supported?

3.3 Other guiding considerations

3.3.1 MBS Review Taskforce approach

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

1. **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access too many specialist services remains problematic, with some rural patients being particularly under-serviced.
2. **Best practice health services**—one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although MSAC plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.

3. **Value for the individual patient**—another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.

4. **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

3.3.2 GPPCCC Principles for Primary Health

The GPPCCC over-arching principles on the delivery of primary care recommend the development of a new funding model to support high quality, person-centred primary health care based on GP stewardship of the health system, supported by multidisciplinary team-based arrangements.

The GPPCCC defines person-centred care as "a way of thinking and doing things that sees the people using health services as equal partners in planning, developing and monitoring care to make sure it meets their needs". This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to achieve the best outcome.

This approach and these principles are strongly supported by the Taskforce and were also taken into consideration during deliberations on primary care recommendations.

3.3.3 Needs and evidence

Throughout all recommendations assessed by the Taskforce, a range of "needs" have been articulated. These include:

- **Perceived health needs:** informed by the consultation process, the need for health services as expressed or desired by an individual or community.
- **Professionally defined health needs:** informed by the consultation process and subsequent bilateral meetings, the need for health services as recognised by health professionals.
- **Evidence informed health needs:** informed by the work of the clinical committee, reference group or working group, the need is based on and supported by evidence.
- **Broader community needs:** informed by best care for patients, how the community as a whole might benefit, and what gaps might be filled.

3.3.4 Wider system implications and possible segmentation

The MBS Review has been designed to improve patient care, help modernise the system, and promote an improved focus on the patient and clinical best practice providing greater value for money. In line with the MBS Review objectives, any recommendation provided to the Government for endorsement has been carefully considered in the context of the role of the MBS, sectoral fragmentation and/or cost-shifting wherever possible.

3.3.5 Consultation Feedback

Draft recommendations from the GPPCCC and the PCRGs reports were released for consultation in late 2018 and early 2019 respectively. The GPPCCC and PCRGs then considered feedback from over 600 stakeholders, before providing revised recommendations as part of their Final Report to the Taskforce.

3.3.6 Ongoing considerations

- 10-year Medical Research Future Fund investment plan,
- Supporting older Australians commitment – strengthening safety, quality, access to, and integrity of Australia's aged care system,
- The 2030 Mental Health Vision,
- 10-year Primary Health Care plan, and
- 10-year National Preventative Health Strategy.

4 Primary Care Recommendations

Below are excerpts from each GPPCCC and PCRG's Final Report to the Taskforce. The Taskforce's findings and advice on the recommendations can be found following the recommendation's rationale.

References for each GPPCCC and PCRG report can be found at Section 7 of this document.

A glossary of terminology, definitions, acronyms and names can be found at Section 8 of this document.

A list of members for the GPPCCC and PCRGs can be found at Appendix A.

A list of all items reviewed by the GPPCCC and PCRGs can be found at Appendix B.

General Practice and Primary Care Clinical Committee

The GPPCCC is part of the third tranche of Clinical Committees of the MBS Review. It was established in October 2016 to make recommendations directly to the Taskforce, and to other Clinical Committees (from a GP provider and requester perspective). The Taskforce asked the GPPCCC to review MBS items pertaining to services rendered, referred and requested by GPs.

The GPPCCC reviewed 111 items in total and made recommendations, requests and statements based on the best available evidence and clinical expertise, in consultation with relevant stakeholders, Specialists and Consultant Physicians.

The work of the GPPCCC was split between two phases:

1. Phase 1: October 2016 – April 2017 (Section 4.1)
2. Phase 2: February 2018 – July 2018 (Section 4.2)

Throughout their deliberations, the GPPCCC referred a number of matters to other clinical committees for consideration. While not directly relating to primary care, a number of these referred issues related to how primary care can best meet the needs of the patient.

4.1 General Practice and Primary Care Clinical Committee – Phase 1

The views and recommendations in the Phase 1 report provided the Taskforce with a progress update on the work of the GPPCCC. The report is/was not intended for release for public consultation and was submitted to the Taskforce for consideration in 2017.

Many issues/suggestions relating to items assigned to other Clinical Committees have been directed to those Clinical Committees for their consideration. (For example, requestor perspectives on Pathology and Diagnostic Imaging items have been submitted to the Diagnostic Medicine Clinical Committee). These Clinical Committees are expected to make recommendations directly to the Taskforce.

4.1.1 General Practice and Primary Care Clinical Committee's Areas of Responsibility (Phase 1)

The GPPCCC was established in October 2016 to make recommendations to the Taskforce regarding MBS items in its area of responsibility, based on clinical expertise and rapid evidence review. The Taskforce asked the GPPCCC to review prioritised items for services rendered, referred (e.g., secondary or tertiary care services, such as Consultant Physician attendances) and requested (e.g., Diagnostic Imaging and Pathology services) by GPs; and to develop recommendations on supporting GPs as stewards of the healthcare system.

This interim (Phase 1) report outlines the GPPCCC's recommendations regarding mechanisms that could support GP stewardship, MBS items covering services referred and requested by GPs, and an initial set of MBS items covering services rendered by GPs. The GPPCCC prioritised 111 MBS items[1] for review in this first phase of work, which culminated in this interim report. In the 2014/15 financial year (FY), these items accounted for approximately 29 million services and $1.6 billion in benefits.

4.1.2 General Practice and Primary Care Clinical Committee's Review Approach (Phase 1)

This interim (Phase 1) report synthesises the GPPCCC's recommendations on both GP stewardship and the 111 MBS items within the scope of its first phase of work. The GPPCCC developed the recommendations on GP stewardship, and the item-level reviews took place within working groups, with final approval granted by the GPPCCC.

Work was performed across five full GPPCCC meetings and seven working group meetings, during which the GPPCCC developed recommendations and rationales. The review drew on various types of MBS data, including

- data on utilisation of items (services, benefits, consumers, clinicians and growth rates),
- service provision (type of clinician, geography of service provision),
- consumers (services per consumer),
- co-claiming or episodes of services (same-day claiming and claiming with specific items over time), and
- additional clinician and consumer-level data, when required.

The review also drew on data presented in the relevant published literature, all of which is referenced in the report.

All recommendations (including recommendations and suggestions directed to other Clinical Committees focus on the objectives of the MBS Review: improve access to medical services, encourage best practice, increase value for consumers and the health system, and simplify the MBS to improve both consumer and clinician experience (for example, through improved transparency around services billed), as well as the efficiency with which the MBS is administered.

The suggested recommendations from both the Pathology Working Group and the Diagnostic Imaging Working Group have been forwarded in a memorandum to the Diagnostic Medicines Clinical Committee, set up by the Taskforce to consider the perspectives of both providers and requesters on selected Pathology and Diagnostic Imaging items.

Working Group structure

Four working groups were established in Phase 1 to support the GPPCCC:

- Rendered Services Working Group

[1] Note that the number of items does not include "NK" items. See Glossary for full definition of "NK" items.

- Diagnostic Imaging Working Group
- Pathology Working Group
- Referred Services Working Group

In addition, members of the Consumer Panel and the GPPCCC formed a Consumer Joint Working Group to develop recommendations on GP stewardship.

Details on the membership of the GPPCCC and the four working groups can be found at Appendix A.

4.1.3 General Practice and Primary Care Clinical Committee Recommendations (Phase 1)

Below are the recommendations from the GPPCCC Phase 1 report. Phase 2 follows. The recommendations seek to better prioritise MBS and broader funding to support effective, longitudinal care for patients.

NOTE: Phase 1 recommendations were not included in the work undertaken by the Working Group, as the Phase 1 recommendations had already been considered by the Taskforce before this work began (see Section 3 of this report for more information).

Stewardship recommendations

Australia performs well on health outcomes—including having one of the highest life expectancies at birth—and its population has high levels of self-perceived health (1; 2). However, these benefits are not equitably distributed across the population, with worse outcomes evident in remote and rural areas, and among Aboriginal and Torres Strait Islander Australians. Although healthcare spending is increasing as a proportion of gross domestic product (GDP) (3), there is still considerable geographic variation in the use of many health professional services.

This suggests that there are opportunities to improve the consistency of access to high-value, best-practice health services, and to reduce low-value care and waste in health resources.[2]

High-quality primary care is the cornerstone of a high-performing healthcare system, and GPs have a central role as gatekeepers—a principle strongly supported by the health industry in Australia. The central nature of the GP's role within the healthcare system is reflected in the volume of services directly initiated by GPs, which represent over half of all MBS and PBS activity and expenditure (4). With this in mind, the GPPCCC sought to identify mechanisms that would enable the best use of healthcare resources at the individual clinician level, whilst ensuring best-practice care.

Both in Australia and overseas, there has been interest in supporting the role of GPs as stewards of healthcare resources. According to a position statement by the Australian Medical Association (AMA), stewardship in this context involves maximising the quality of care and protecting consumers from harm while ensuring affordable care remains available in the future (e.g. by avoiding or eliminating wasteful healthcare expenditure) (5). With this in mind, the GPPCCC has developed a set of recommendations to support GP stewardship, all of which are designed to complement the MBS changes suggested within the item-level reviews.

[2] Low-value care is defined as "services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits."

The GPPCCC considered a number of complementary mechanisms that could support better GP stewardship and, where possible, has identified practical actions that could be implemented with this goal in mind (see Figure 1). The GPPCCC started by identifying seven possible areas in which stewardship could be enabled, and it then considered levels of impact and feasibility for each area. The GPPCCC also considered whether it was the best body to make recommendations in these areas. The resulting recommendations offer solutions to issues the GPPCCC particularly wanted to highlight within these seven areas.

The GPPCCC acknowledges that parallel primary care reform is well underway in other domains. Important changes that have already occurred will complement the changes recommended here.

Figure 1: GPPCCC Phase 1 – Mechanisms to support GP stewardship
Developed by the General Practice and Primary Care Clinical Committee

		Key Examples
1	Consumer partnership	• Support shared, informed decision-making (including financial consent • Strengthen availability of health information for consumers • Strengthen pathways for non-adversarial complaints resolution
2	Service delivery systems	• Support case conferencing, to improve integration of care (both prior to and at the point of hospital discharge, as well as in the community)
3	Decision support and educational enablers	• Support development of locally tailored clinical guidelines/pathways (through HealthPathways) • Integrate HealthPathways with decision-support tools and electronic requesting/referring mechanisms
4	Clinical governance and data transparency	• Provide transparency on GP practice patterns to aid in self-reflection and quality improvement, including information on requesting, referring and prescribing
5	Leadership and role modelling	• Encourage GP training organisations and PHNs to promote and develop stewardship and leadership in primary care; such as through mentorship and supervision relationships, training modules, and leadership programs

Consumer partnership

Partnering with consumers is central to the stewardship model, reflecting both the role that consumers play in health resource utilisation and the extent to which their actions enhance (and at times diminish) appropriate stewardship of healthcare resources. The General Practice–consumer consultation is intended to foster this partnership. Ideally, the GP elicits and discusses the consumer's ideas and beliefs about their health, as well as their fears and concerns about current problems and their expectations regarding their healthcare. The GP then outlines the relative risks of differential diagnoses and management options, seeking to partner with the consumer in his or her decision-making. The overall aim of the consultation is to address the consumer's presenting concerns and existing health problems (6), while also reducing the risk of future problems through evidence-based health promotion and disease prevention strategies (7).

The consumer partnership recommendations seek to ensure that consumers are knowledgeable about their healthcare options, understand their rights under the MBS, are informed about potential out-of-pocket costs and have access to a process for resolving any disputes. They were developed based on the deliberations of a Joint Working Group, which consisted of members from the Consumer Panel and the GPPCCC, operating within the MBS Review.

Recommendation 1 – Strengthen the availability of health information for consumers, both through Commonwealth Government publications and through the HealthPathways currently being developed by PHNs and their partners (including Local Health Districts/Local Hospital Districts)

Through Commonwealth Government publications:

a. Develop and raise awareness of

   (i) Consumer-friendly descriptors of MBS services.

   (ii) Consumer-friendly interfaces for understanding what is and is not covered by the MBS (similar to the online MBS item search aimed at clinicians).

   (iii) A consumer-guide to the MBS in the form of a booklet, available at primary care practices and online.

b. Make government funding of clinical guidelines contingent on the production of an accompanying plain language version aimed at consumers.

Through PHNs:

a. Consider the development of consumer-focused, publicly accessible versions of PHN/Local Hospital Networks (LHNs) HealthPathways guidelines, co-designed by consumers and clinicians

Rationale 1

Providing plain language written resources about the MBS and locally relevant healthcare pathways will enhance the health literacy of the Australian community and empower consumers to be more active participants in their own healthcare choices.

GPPCCC Phase 1 Recommendation 1 – Referred

This recommendation was addressed as part of GPPCCC Phase 2 Recommendation 8, which seeks to develop advice and support mechanisms to activate and engage patients in their own care planning, including assessment and support of patient health literacy.

Recommendation 2 - Mandate informed consent for MBS-reimbursable services, including financial consent

This should involve:

a. providing and discussing treatment options, including alternative clinicians (where relevant and available),

b. disclosing expected out-of-pocket costs, and

c. encouraging all healthcare professionals who offer MBS-reimbursable services to provide their fees and bulk-billing policies online.

Rationale 2

Out-of-pocket costs are a major barrier to equitable healthcare, impeding access and reducing adherence to agreed management plans.

The Royal Australian College of General Practitioners' (RACGP) Standards for General Practice require that practices "inform patients about the potential for out-of-pocket expenses for healthcare provided within [the] practice and for referred services," but they do not mandate that the practice provide details regarding the latter.

Other professional bodies also encourage the provision of financial information, including expected out-of-pocket costs, prior to treatment.

GPPCCC Phase 1 Recommendation 2 – Referred

This recommendation was addressed as part of GPPCCC Phase 2 Recommendation 7, which seeks to increase access to care facilitation, including access to information and choices about cost, quality and availability of care.

Note: *This concept was also considered by Principles and Rules Committee (PaRC) on 11 July 2017 (raised via Anaesthetics Clinical Committee). PaRC endorsed the principle of fee transparency, noting its value in informing choice of doctor and potentially driving fees towards the median. PaRC agreed to recommend to the Taskforce the development of a website, maintained by the Department, providing provider billing information.*

The Government's Medical Costs Finder website was launched in December 2019 and aims to support patients to assess in-hospital specialist costs.

Recommendation 3 – Develop a non-adversarial system for resolving complaints about consumers' out-of-pocket healthcare costs and disagreements about clinicians' charges

Rationale 3

At present, there are insufficient opportunities for consumer complaints to be handled in an independent and non-adversarial manner.

- Current complaints processes can be adversarial in nature, which does not tend to encourage mediation and communication. This results in missed opportunities to improve healthcare.
- Although there are bodies established to handle health outcome, quality and malpractice complaints, there are no completely independent bodies that handle complaints focused purely on failure to provide financial consent, or that allow consumers to report issues regarding costs of services.

Additional Comments

In addition to the formal recommendations listed above, the Joint Working Group identified the following opportunities for consumer partnership.

- Encourage consumers to build on their health literacy and take greater ownership of their own healthcare. For example, consumers could be encouraged to:
    - Ask the five questions suggested by 'Choosing Wisely':
        - Do I really need this test or procedure?
        - What are the risks?
        - Are there simpler, safer options?
        - What happens if I don't do anything?

        - What are the costs?
    - Take systematic notes during health interactions (e.g. use structured templates or exercise book notetaking during clinical interactions to record the reasons for a treatment or drug they are taking).
    - Use apps that provide access to clinical information in electronic health records (such as My Health Record).
- Include consumer-friendly indications on prescriptions.
    - This should *not* be mandated, as some consumers have confidentiality and privacy concerns. Instead, the consumer should be left to decide whether he or she would prefer consumer-friendly indications to be included.
- Encourage the use of brief exit surveys for consumers, covering questions such as:
    - Based on your experience today, would you recommend this practice to a family member or friend?
    - Were your healthcare needs met today?
    - Do you understand the actions you must take related to your care following today's visit?
    - Were you included in decisions about your health today?

GPPCCC Phase 1 Recommendation 3 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Service delivery systems

Service delivery systems include infrastructure and processes through which consumers receive clinical care (for example, how team care is arranged and delivered). The recommendation below relates to case conferencing specifically, which the GPPCCC decided should be an area of focus. The GPPCCC prioritised case conferencing because:

a. it is an area in which care can be improved,

b. it is an area where recommendations are feasible and will have an impact, and

c. the GPPCCC is best placed to make recommendations in this area.

Recommendation 4:

Support PHNs in educating people about and encouraging the use of case conferencing where appropriate — both prior to and at the point of hospital discharge, as well as in the community — to ensure that care is integrated across all domains. Consumers should be involved where possible so that health practitioners can partner with them and help them to participate actively

in their care and navigate the healthcare environment. Where a care plan already exists for a consumer, the case conference outcomes should be integrated into that care plan.

Support the use of flexible models, including:

a. Asynchronous case conferencing, which does not require all participants to take part at the same time. For example, decisions made during a multidisciplinary hospital team conference prior to hospital discharge would be discussed with the GP (e.g. through a doctor–doctor conversation via telephone or email) in a dynamic way that provides the GP with an opportunity to contribute to and/or alter the discharge plan. The GP could then bill a case conferencing item number for his or her contribution.

b. Alternative representatives, which allows the practice nurse or other suitable health professional to represent the GP if he or she is unable to participate in a case conference.

Note: The GPPCCC requested that the AHRG consider recommendations to improve the participation of allied health practitioners in case conferencing where appropriate.

The AHRG addressed case conferencing as part of AHRG Recommendation 8, which proposed case conferencing for children with a potential Autism Spectrum Disorder (ASD), Complex Neurodevelopmental Disorder (CND) or disabilities diagnosis.

Rationale 4

This recommendation aims to support access to best-practice health services. It is based on the following observations:

- There is evidence that GP involvement in the care of consumers in hospital—both for discharge planning and coordination (as part of a multidisciplinary integrated care team)—leads to better outcomes (8). In addition to improving integration of care, improving the use of case conferencing MBS items would strengthen both relationships and communication between GPs and other medical specialists.
- The GPPCCC formed the view—based in part on usage statistics, including geographical distribution and changes over time—that case conferencing is currently underutilised, and that it has the potential to enhance consumer outcomes.
- PHNs are the most appropriate bodies to encourage and promote case conferencing (both across care settings and within the community) due to their understanding of local health resources, systems and challenges, as well as their close ties with local GPs and LHNs/Local Hospital Districts (LHDs).
- Case conferencing is not easily organised within the GP workflow because it is often difficult to coordinate with other clinicians' schedules. As a result, a major barrier to case conferencing is the logistical challenge of scheduling meetings between hospital-based practitioners, GPs and other community-based health clinicians, and consumers. Access to discharge case conferencing for consumers with complex care needs, in particular, could be improved if this logistical challenge could be surmounted.
- The GPPCCC believes that it is important for clinicians to be able to decide how best to involve consumers on a case-by-case basis, but with a default expectation that the consumer will attend a case conference.
- In some circumstances, real-time consumer participation in a case conference may not be clinically appropriate. For instance, some clinical details or work-in-progress discussions may be confronting.

Alternatively, the consumer's presence may discourage the frank exchange of views and suggestions between health practitioners due to the potential for misinterpretation.

- In situations where a consumer does not participate in real time, there should be a requirement that details of the discussion are communicated to the consumer. This will keep the consumer informed of the options considered by the team and let him/her have input into the management plan.

GPPCCC Phase 1 Recommendation 4 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale, noting asynchronous GP conferencing and alternative representatives are also captured under Phase 2 Recommendation 2's VPE model and case conferencing is addressed in GPPCCC Recommendation 4.6.

Decision support and educational enablers

Recommendation 5:

The GPPCCC supports the efforts of PHNs to develop HealthPathways clinical guidelines in collaboration with LHNs/LHDs, other local clinicians, and consumers. HealthPathways are web-based and provide detailed recommendations for the evidence-based management of a wide range of common conditions, taking into account local resources and offering links to local clinicians, both public and private. HealthPathways are evolving to integrate with decision-support tools and electronic requesting/referring mechanisms.

Rationale 5

This recommendation aims to ensure that consumers receive best-practice, high-value care, delivered in the right place, at the right time and by the right clinician, in the context of local resources. It is based on the following observations.

- Decision-support, education and clinical governance mechanisms can help clinicians and consumers to confidently navigate the health system. In particular, they can help to identify relevant local health resources and initiate appropriate investigation and treatment pathways in that context.
- PHNs, in collaboration with their corresponding LHNs, are the most appropriate bodies for developing and integrating care pathways. Indeed, they are already doing so in many regions of Australia.
- Care pathways should be developed in collaboration with local health practitioners, and they should reflect local systems and health resources, as well as the relevant evidence and guidelines.
- Decision-support tools (both for diagnostic and therapeutic services) and requesting/referring mechanisms should be suitable for the local health systems and resources and relevant to local care pathways.

GPPCCC Phase 1 Recommendation 5 – Endorsed for Government consideration

The Taskforce supports the GPPCCC's rationale and acknowledges work needs to be undertaken (outside of the MBS) to assist with evidence-based and integrated care pathways, including appropriate decision support tools.

Clinical governance and data transparency

In the context of stewardship, data transparency allows clinicians to see and reflect on the care they provide. This is an essential component of clinical governance. There is ongoing advocacy for greater transparency in healthcare, covering broad-reaching areas with varied goals and outcomes, and there are already international examples of providing cost, quality and outcome data to a wide range of participants, from clinicians to payers to consumers. In 2012, the Australian Commission on Safety and Quality in Health Care reiterated the need for greater transparency for consumers and funders as part of the National Primary Healthcare Strategy (9). In the context of enabling and encouraging stewardship behaviours, the GPPCCC focused on changes that are feasible and will have the most impact in terms of promoting stewardship.

Recommendation 6 – Provide data to GPs on carefully selected metrics that measure their requesting, referring and prescribing behaviours, compared to a benchmark of their peers

This should be implemented in the following way:

a. Begin by using MBS, PBS and PIP data sources that are readily available and understood. In the future, other sources may be available.

b. Initially focus on GPs as recipients (including as individual GPs, as well as groupings such as general practices and PHNs) as a way of providing an opportunity for GPs to reflect on their performance (relative to their peers) as stewards of the healthcare system.

c. Provide data in a way that supports GPs to reflect on their performance. Specifically, this involves:

   (i) Providing accompanying educational materials where appropriate, such as clinical guidelines or evidence-based resources on requesting behaviours.

   (ii) Delivering the data as immediately as possible, so that it reflects the GP's current practice patterns and supports engagement in quality improvement programs.

   (iii) Supplementing this method of 'pushing' data to GPs with a mechanism (such as a data portal) that allows GPs to 'pull' data that reflects their interests and quality improvement priorities.

d. Start with metrics that are obvious representations of unexplained variation or that provide evidence of inappropriate use of healthcare resources (e.g. repeat testing).

   (i) Include, where relevant, methods to support appropriate interpretation in recipient GPs' particular contexts (for example, by capturing variability in the socioeconomic status of a practice's local area).

e. In particular, metrics should focus on (a) utilisation and (b) continuity of care. This focus should then broaden to include carefully developed 'quality' metrics. For example, utilisation metrics could focus on variations in Pathology and Diagnostic Imaging requesting patterns or repeat testing, and continuity metrics could focus on the proportion of a consumer's primary care provided by the particular GP. Selected metrics should be:

   (i) Relevant: There should be strong evidence that the metric is valid—i.e. that it reflects an outcome of interest or provides clearly desirable data (e.g. the percentage of consumers with type 2 diabetes whose HbA1c is less than 8 per cent).

   (ii) Accurate and reliable: The metric should be well defined and consistently interpreted (e.g. standardised) and presented with appropriate risk adjustment to account for differences in patient populations.

(iii) Readily available: The data should be consistently obtainable across clinicians/consumers without undue administrative burden.

(iv) Usable: The metric should provide tangible and timely feedback for decision-making (e.g. practice change or referral choice), with a clear line of accountability for the specific clinician (i.e. it is attributable).

(v) Appropriate/non-distortionary: Monitoring the metric should not create perverse incentives or cause unintended consequences. (This may be achieved by balancing complementary indicators.)

Rationale 6

- Focusing on a small set of metrics for GPs (based on available MBS, PBS and PIP data sources will ensure that implementation of this recommendation is achievable.
- As previously noted, GPs are central to the healthcare system, directly initiating services that represent over half of MBS and PBS costs (4). Providing GPs with the opportunity to reflect on their performance will drive ownership of their role as stewards of healthcare resources.
- Introducing feasible and easily attainable metrics and gradually increasing transparency (e.g. from de-identified to identified, from internal use to publicly shared) will allow the health community to gain experience in understanding the data and adjusting practice patterns appropriately. It will also afford clinicians an opportunity to engage with the ongoing design of transparency efforts.
- In recognition of the different socioeconomic make-up of general practices, it may be necessary to 'risk-adjust' results against benchmarks. For example, metrics on the rate of requesting/referrals need to be interpreted in the context of local demographics at the practice level.
- Targeted data highlighting GP practice patterns, relative to peers, has been successful in supporting GPs to re-evaluate practice. For example, previous individually targeted feedback on requesting habits has been useful in reducing unnecessary requests (10).
- In contrast, untargeted data release has occasionally led to unexpected responses. For example, use of percentile charts on public websites may result in across-the-board increases in requesting, regardless of the clinician's original practice pattern.

GPPCCC Phase 1 Recommendation 6 – Referred

This recommendation was addressed as part of GPPCCC Phase 2 Recommendation 2, which proposes GPs being supported to drive data-driven improvements in quality of care via the VPE model.

Leadership and role-modelling

Recommendation 7 – Encourage GP training organisations and PHNs to take greater responsibility for promoting and developing stewardship and leadership

This could be achieved by increasing the focus on:

a. formal mentorship and supervision relationships in GP registrar training programs,

b. core modules for clinicians that focus on

(i) the importance of developing critical clinical reasoning skills, and

(ii) taking responsibility for access to the healthcare system (and the impact of such access) for the community as a whole,

and

c. specific leadership programs.

Rationale 7

- Although principles of leadership and stewardship can be taught, experiencing good stewardship in action is the most powerful and effective way of learning how to be a role model.
- Recognising teachers as leaders is important, because leadership and role-modelling go hand in hand with teaching. The current method of delivering leadership teaching is not enabling good leaders in stewardship specifically, despite college curricula that place emphasis on teaching and the development of leaders.
- Promotion of leadership is critical. This could be achieved by creating opportunities to obtain joint qualifications—for example, Fellow of the RACGP/Fellow of the Australian College of Rural and Remote Medicine (ACRRM) in conjunction with a graduate degree.
- The importance of good leadership should be formally acknowledged, and the notion of stewardship should be more overt within curricula. The respective colleges have a critical role to play in updating their curricula to focus more on developing stewardship through their mentorship programs.
- There are opportunities to improve the clinical reasoning skills of primary care clinicians. For instance, MBS data illustrates wide variation in the volume of pathology and radiology tests requested. Addressing this variation would lead to more individualised use of healthcare resources.

GPPCCC Phase 1 Recommendation 7 – Referred

This recommendation was addressed as part of Phase 2; encouraging and cementing GP stewardship is a key theme of many Phase 2 recommendations.

Recommendations for acupuncture attendances (items 173–199)

The MBS currently has five items that cover the provision of acupuncture by Medical Practitioners.

- item 173 applies to acupuncture services provided by any Medical Practitioner. It attracts a smaller fee than items 193, 195, 197 and 199.
- Four items (193, 195, 197 and 199) may only be performed by GPs who are “qualified medical acupuncturists,” where the Medicare Australia Chief Executive Officer (CEO) has received a written notice from the RACGP stating that the person meets the skill requirements for the provision of acupuncture. These items differentiate between individual and group (hospital) therapy. items for individual therapy in consulting rooms (193, 197 and 199) are time-tiered, while the fee for group hospital therapy (item 195) is based on the number of consumers in the group.
- All five items include any consultation service provided on the same occasion as the acupuncture service, and any other attendance on the same day for the condition for which acupuncture was given.
- For the purpose of payment of MBS benefits, acupuncture is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture (for example, by application of ultrasound, laser beams, pressure or moxibustion).

Recommendation 8 – Delete item 173

Rationale 8

This item does not require the clinician to be appropriately credentialed to provide acupuncture services.

GPPCCC Phase 1 Recommendations 8 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Recommendation 9 – Revise item 193-199 descriptors

Revise item descriptors for items 193-199 to:

a. define the credentialing required to attract MBS benefits for acupuncture services to include all Medical Practitioners (rather than specifying GPs only),

b. clarify that the service duration refers to the period of time during which the clinician is physically present in attendance with the individual patient (and not the 'needle time'), as is the case for other MBS attendance items,

c. The proposed item descriptors and explanatory notes are below:[3,4]

ITEM 193: PROFESSIONAL ATTENDANCE AT A PLACE OTHER THAN A HOSPITAL

Professional attendance at which acupuncture is performed

a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia

at a place other than a hospital

by the application of stimuli on or through the surface of the skin by any means

including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed

involving less than 20 minutes of physical attendance by the Medical Practitioner to the individual patient (whether continuous or non-continuous).

ITEM 195: CONSULTATION AT A HOSPITAL

Consultation at which acupuncture is performed

[3] The reference to acupuncture items within Explanatory note A.5 should also be removed as the table of acupuncture attendance items will not be for the exclusive use of GPs.

[4] These recommended changes are made in the context of "PROFESSIONAL SERVICES", which applies to all Category 1 items, of which acupuncture items are a part.

a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia

b) at a hospital

on one or more patients on one occasion

by the application of stimuli on or through the surface of the skin by any means

including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed

ITEM 197: PROFESSIONAL ATTENDANCE AT A PLACE OTHER THAN A HOSPITAL

Professional attendance at which acupuncture is performed

a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia

b) at a place other than a hospital

c) by the application of stimuli on or through the surface of the skin by any means

d) including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed

involving at least 20 minutes of physical attendance by the Medical Practitioner to the individual patient (whether continuous or non-continuous).

ITEM 199: PROFESSIONAL ATTENDANCE AT A PLACE OTHER THAN A HOSPITAL

Professional attendance at which acupuncture is performed

a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia

b) at a place other than a hospital

c) by the application of stimuli on or through the surface of the skin by any means

d) including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed

involving at least 40 minutes of physical attendance by the Medical Practitioner to the individual patient (whether continuous or non-continuous).

and

d. the proposed explanatory notes (A.18) for acupuncture attendance items (193–199) are below:

The service of "acupuncture" must be performed by a Medical Practitioner and itemised under item 193, 195, 197 or 199 to attract benefits. These items cover not only the performance of the acupuncture but

include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given.

items 193, 195, 197 and 199 may only be performed by a Medical Practitioner who also has endorsement of registration for acupuncture with the Medical Board of Australia (see credentialing requirements from Medical Board of Australia for a definition). Other items in Category 1 of the Schedule should not be itemised for professional attendances when the service "acupuncture" is provided.

For the purpose of payment of Medicare benefits "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, e.g. by application of ultrasound, laser beams, pressure or moxibustion, etc.

Note: details of the process through which acknowledgement of credentials occurs should be determined by the Department of Human Services (DHS) in consultation with the Department of Health (DoH).

Rationale 9

This recommendation focuses on ensuring that acupuncture attendance items reflect the level of high-quality care funded by the MBS.

- There is sufficient clinical evidence of safety and efficacy to justify the continued listing of MBS items for acupuncture services (11).
- In order to promote high-quality acupuncture in the primary care setting, defining credentials clearly (rather than the type of clinician) will enable quality assurance. Credentialing requirements for service clinicians is the most appropriate way of ensuring access to high-quality services. Credentialing implies awareness of appropriate clinical indications.
    - The GPPCCC considered stipulating appropriate use criteria to ensure the provision of high-quality, evidence-based care. However, it decided against using appropriate use criteria due to the rapidly evolving nature of the evidence base for clinical indications for acupuncture.
    - item 173 does not differ from the other individual therapy items (193, 197, 199), other than allowing laxity on credentialing requirements. item 173 therefore does not add to the other acupuncture items present.
- Medical practitioners providing these acupuncture services may be seeing more than one consumer at once and claiming the longer duration items (Level C and D) because of the effect this has on the duration of the consult. For this reason, a definition should be provided for duration spent with the consumer.

GPPCCC Phase 1 Recommendations 9 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Repair of wounds (items 30026–30049)

The MBS currently has 10 items that cover Medical Practitioner services for repairing wounds requiring suture, tissue adhesive resin or clips. These items do not cover the repair of a wound at the time of surgery.

Three factors differentiate the ten items: wound length, wound depth and wound location (on the face or not on the face). There are also separate items for deeper wounds (items 30041/42 and 30048/49).[5]

Recommendation 10 - Revise the item descriptors to differentiate between wound lengths of not more than 5 cm and wound lengths of more than 5 cm (i.e. make the cut-off point a wound length of 5 cm, rather than the current 7 cm).

Rationale 10

This recommendation focuses on ensuring that item descriptors (and the associated MBS benefits available to consumers) accurately reflect differences in the level of professional involvement required.

It is based on the following observations:

- Wound depth, size, location and contamination status are appropriate factors for discriminating between the different levels of professional involvement required in wound repair.
- A cut-off point of 5 cm is a more accurate reflection of the differences in professional skill required to repair small and large wounds. The existing 7 cm cut-off does not discriminate adequately between large wounds of 6–7 cm and smaller wounds.

The GPPCCC also noted the following:

- Provision of this service in the primary care setting is just as safe and effective as in the Emergency Department setting and may be more cost-effective.
    - GPs currently provide 92–97 per cent of services for these 10 MBS items. It is difficult to ascertain what proportion of services performed in the Emergency Department setting could be performed in General Practice (noting that the vast majority of emergency attendances are in public hospitals and are therefore not funded by the MBS).
- The current MBS fee for wound repair may be inadequate for financially sustainable provision of this service in the primary care setting. This may prompt some general practices to redirect consumers to the Emergency Department.
    - Supplies and assistance are a significant outlay. This includes sterile packs, suturing kits and additional practice resources (such as nursing assistance).
    - The nature of the presenting complaint also disrupts the scheduling of appointments in General Practice, taking considerable unplanned time.

Note: The GPPCCC requested the NPRG to consider whether wound repair items should be included as services provided by nurse practitioners, either through an amendment to the existing items or by replicating these items in the part of the MBS that covers services provided by nurse practitioners.

The NPRG considered wound repair as part of:

[5] These items differ depending on the type of provider performing the procedure, denoted “G” for GPs and “S” for Specialists. Note that the MBS Review PARC has made recommendations to remove this “G” and “S” distinction from the MBS, consolidating items into a single set with fees at the current higher “S” level.

- NPRG Recommendation 5, which proposed creating a new MBS item for longer nurse practitioner attendances to support the delivery of complex and comprehensive care, and
- NPRG Recommendation 10, which proposed enabling patient access to MBS rebates for procedures performed by an NP working within their scope of practice.

- Nurse practitioners currently perform suturing in primary health care settings and are appropriately qualified to provide high-quality care.
- The lack of access to Medicare rebates for these services potentially disadvantages consumers who seek services from a nurse practitioner, particularly in circumstances where a nurse practitioner is the only suitably qualified health professional who is readily accessible to deliver those services (e.g. in rural and remote locations).

GPPCCC Phase 1 Recommendation 10 – Referred

This recommendation was referred to the Wound Management Working Group.

Recommendation and request directed to other Clinical GPPCCCs regarding telehealth items for patient-end clinical support (items 2100–2220)

The MBS currently has 12 items that cover Medical Practitioners providing clinical support to their patients during video consultations with Specialists or Consultant Physicians. Although telehealth specialist services can be provided when there is no patient-end clinical support service, these items also allow for the participation of another Medical Practitioner at the patient-end of the consultation. There are equivalent items for patient-end clinical support by other types of health practitioner, such as participating optometrists, nurse practitioners, midwives, practice nurses, Aboriginal and Torres Strait Islander Health Practitioners or Aboriginal Health Workers.

The items are both time-tiered and location-dependant. There are also various stipulations within the MBS that define appropriate claiming of these items, including eligible geographical areas (for those not residing in a residential aged care service or at an Aboriginal Medical Service) and the requirement for both an audio and visual link.

Request: The GPPCCC requested that the AHRG consider whether the MBS should include patient-end clinical support services provided by allied health practitioners for telehealth consultations with Specialists or Consultant Physicians.

The AHRG considered allied health practitioner telehealth clinical support services as part of AHRG Recommendation 13, which proposed research on the highest-value opportunities for telehealth integration into allied health care and a new item for the provision of telehealth services for patients consulting with an allied health professional via teleconference.

Note: all recommendations relating to telehealth were referred to the Telehealth Working Group.

Rationale

This request focuses on ensuring that access to medical care is available to all Australians, regardless of the consumer's place of residence.

- Patient-end clinical support telehealth services are underutilised in rural and remote areas, and for frail elderly and persons with disability (wherever they reside). (The GPPCCC believes that service volumes are lower than would be expected with optimal use.)
- Poor access to services is primarily due to logistical challenges in scheduling a mutually agreeable time between consumers, the patient-end clinical support clinician and the Specialist/Consultant Physician.
- Introducing access to patient-end clinical support by other members of the primary care team may afford the flexibility required to improve consumer access to Specialist and Consultant Physician care in rural and remote areas, and to frail elderly and persons with disability (wherever they reside).
    - Nurse practitioners, Aboriginal and Torres Strait Islander Health Workers, midwives and optometrists can currently provide patient-end clinical support for telehealth services under alternative MBS items (10983–4, 82150–2, 82220–5 and 10945–8). However, items do not exist for other allied health practitioners.
    - There are specific clinical scenarios where involvement of an Allied health practitioner may be preferable (e.g. the presence of a physiotherapist on behalf of the GP following orthopaedic surgery).

Recommendation 11 - Consider introducing items for GP direct-to-patient teleconferencing for the purposes of providing consulting services to patients in rural and remote areas, and to frail elderly and persons with disability (wherever they reside)

Rationale 11

- Rural and remote consumer access to GPs could be improved by creating alternative methods of communication for these consumers.
- Current telehealth items for GP use are restrictive in terms of the types of consumers that can use these services, the location settings they can be used in, and the clinicians that can offer the service. However, there is a risk that creating telehealth items in innovative areas might increase potentially low-value care. Special emphasis should be placed on improving access for rural and remote residents.

The GPPCCC considered the merits and consequences of expanding telehealth to other areas, taking into account both the consumer's situation (i.e. consumers who have difficulty accessing medical practices) and the clinical situation (e.g. delivering results). However, the GPPCCC acknowledged that this was outside the remit of the review.

GPPCCC Phase 1 Recommendation 11 – Referred

This recommendation was referred to the Telehealth Working Group.

4.2 General Practice and Primary Care Clinical Committee – Phase 2

Note: A list of all items reviewed by the GPPCCC during Phase 2 can be found at the end of the GPPCCC Phase 2 Report.

In Phase 2, the Taskforce asked the GPPCCC to review general consultation items, chronic disease management items, health assessment items and medication management items, and to consider consumer concerns about access to referrals and repeat scripts.

The Committee prioritised 60 MBS items for review in this second phase of work. In the 2016/17 financial year, these items accounted for approximately 118 million services and $5.1 billion in benefits.

The Committee was also asked by the Taskforce to consider the issue of consumer concerns around access to referrals and repeat scripts, raised by the Minister.

The recommendations from the clinical committees were released for stakeholder consultation in September 2018. The clinical committee considered feedback from stakeholders and has provide recommendations to the Taskforce in a Review Report. The Taskforce will consider the Review Reports from clinical committees and stakeholder feedback before

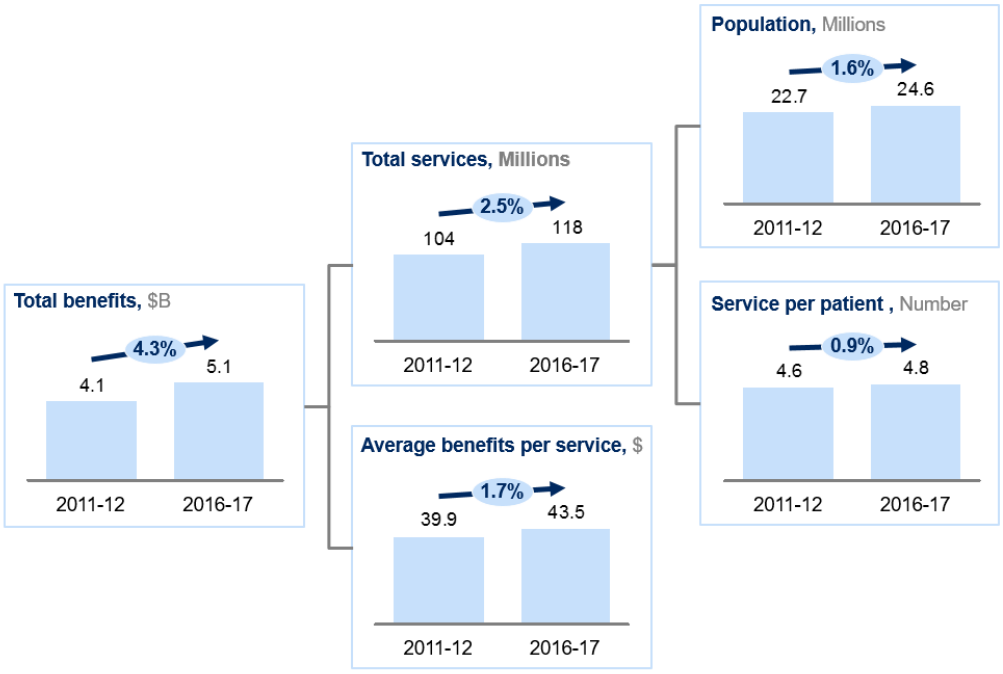
4.2.1 General Practice and Primary Care Clinical Committee's Areas of Responsibility (Phase 2)

In Phase 2, the GPPCCC reviewed 60 MBS items:

- 48 general consultation items,
- 11 chronic disease management items,
- 5 health assessment items, and
- 2 medication management items.

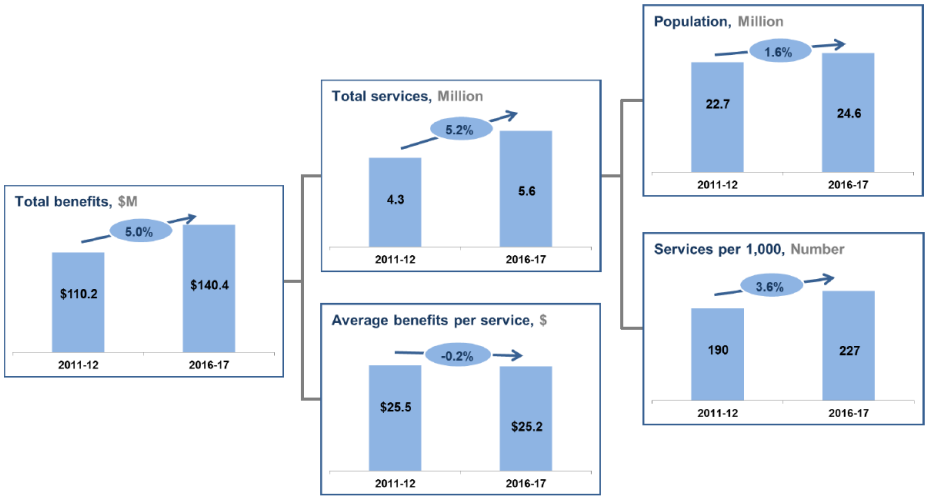
The 48 general consultation items are for consultations by GPs and other medical practitioners in consultation rooms, Residential Aged Care Facilities (RACFs) and other locations. In FY 2016-17, the use by GPs of these items accounted for approximately 118 million services and $5.1 billion in benefits. Over the past five years, service volumes for these items have grown at 2.5 per cent per year, and the cost of benefits has increased by 1.7 per cent per year.

Figure 2: GPPCCC Phase 2 – Key statistics for A1 GP consultations (2011-12 and 2016-17)



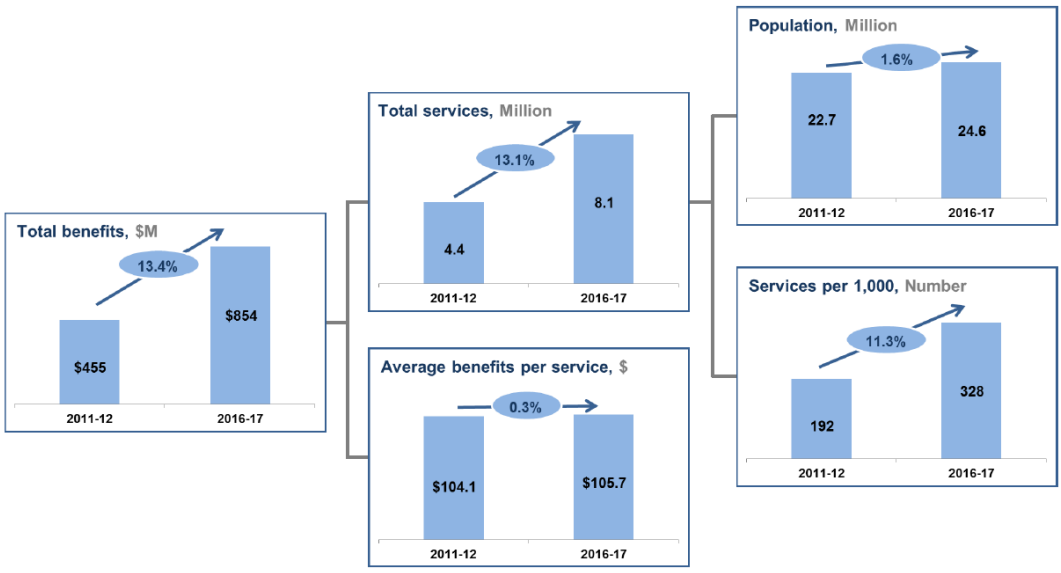
In FY 2016-17, the use by other medical practitioners of Level A-B consultation items accounted for approximately 5.6 million services and $140 million in benefits. Over the past five years, service volumes for these items have grown at 5.2 per cent per year, and the cost of benefits has decreased by 0.2 per cent per year.

Figure 3: GPPCCC Phase 2 – Key statistics for A2 Other Medical Practitioner consultations (2011-12 and 2016-17)



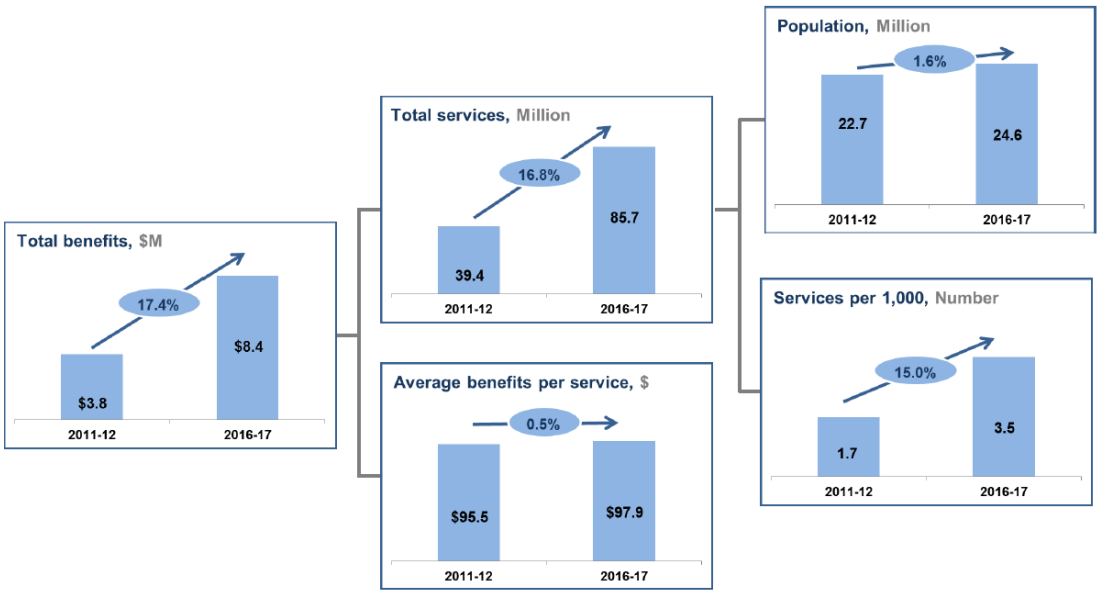
The 11 chronic disease management items include GP Management Plans (GPMPs), Team Care Arrangements (TCAs), and contributions to and reviews of these arrangements. In FY 2016-17, these items accounted for approximately 8.1 million services and $854 million in benefits. Over the past five years, service volumes for these items have grown at 13.1 per cent per year, and the cost of benefits has increased by 0.3 per cent per year.

Figure 4: GPPCCC Phase 2 – Key statistics for Chronic Disease Management items (2011-12 and 2016-17)



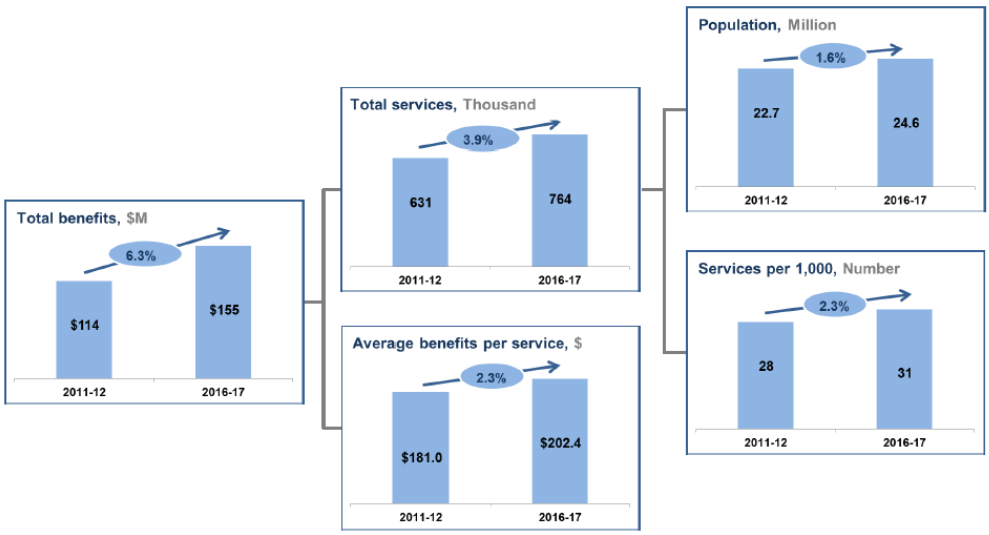
The 11 chronic disease management items also include items for arranging and participating in case conferences. In FY 2016-17, these items accounted for approximately 85.7 thousand services and $8.4 million in benefits. Over the past five years, service volumes for these items have grown at 16.8 per cent per year, and the cost of benefits has increased by 0.5 per cent per year.

Figure 5: GPPCCC Phase 2 – Key statistics for case conferencing items (2011-12 and 2016-17)



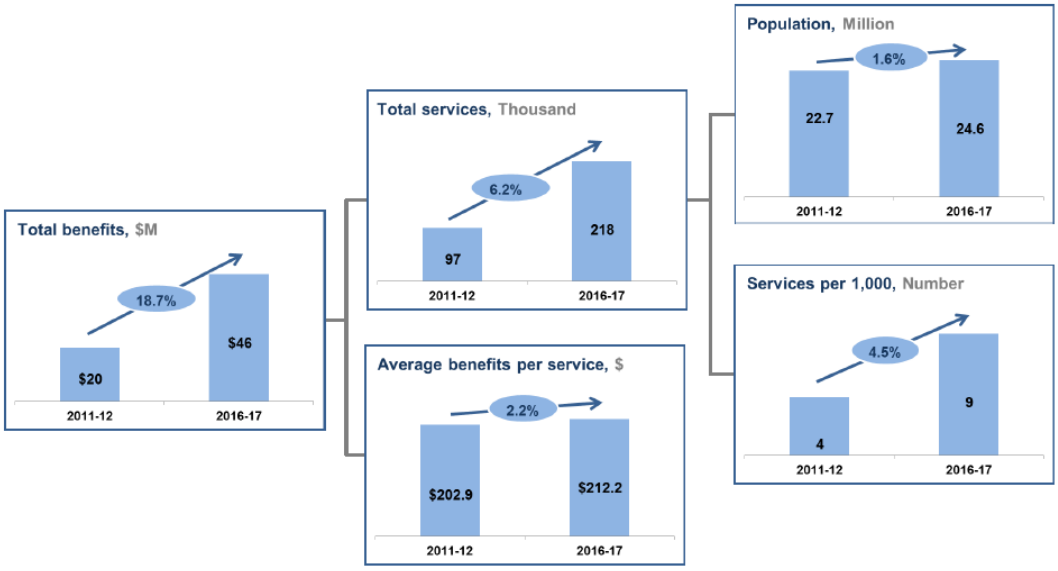
The five health assessment items include four time-tiered health assessment items. In FY 2016-17, these items accounted for approximately 764 thousand services and $155 million in benefits. Over the past five years, service volumes for these items have grown at 3.9 per cent per year, and the cost of benefits has increased by 2.3 per cent per year.

Figure 6: GPPCCC Phase 2 – Key statistics for time-tiered health assessment items (2011-12 and 2016-17)



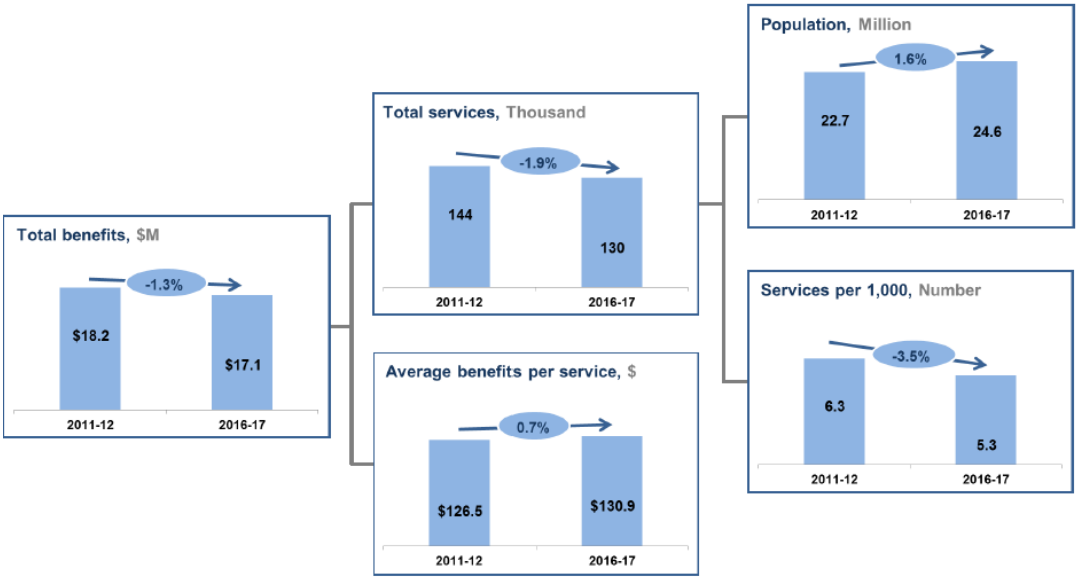
The five health assessment items also include an indigenous health assessment item. In FY 2016-17, this item accounted for approximately 218 thousand services and $46 million in benefits. Over the past five years, service volumes for these items have grown at 6.2 per cent per year, and the cost of benefits has increased by 2.2 per cent per year.

Figure 7: GPPCCC Phase 2 – Key statistics for Indigenous health assessment items (2011-12 and 2016-17)



The two health assessment items are for a GP to work with a community pharmacy or accredited pharmacist to review a patient's medications and develop a medication management plan. In FY 2016-17, these items accounted for approximately 130 thousand services and $17.1 million in benefits. Over the past five years, service volumes for these items have decreased at 1.9 per cent per year, and the cost of benefits has increased by 0.7 per cent per year.

Figure 8: GPPCCC Phase 2 – Key statistics for medication management items (2011-12 and 2016-17)



4.2.2 General Practice and Primary Care Clinical Committee's Review Approach (Phase 2)

The GPPCCC completed a review of its items across five full GPPCCC meetings, two interim full GPPCCC meetings and several additional working group meetings, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including

- data on utilisation of items (services, benefits, patients, providers and growth rates),
- service provision (type of provider, geography of service provision),
- patients (demographics and services per patient),
- co-claiming or episodes of services (same-day claiming and claiming with specific items over time), and
- additional provider and patient-level data, when required.

The Review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were sourced from medical journals and other sources, such as professional societies. The GPPCCC consulted with key stakeholder groups in developing recommendations and rationale.

Public consultation on draft Phase 1 and Phase 2 GPPCCC recommendations was undertaken between September 2018 and March 2019. The GPPCCC considered feedback from the public consultation and made changes to a number of recommendations as is reflected in this report.

Working Group structure

Five clinical Working Groups were established to support the work of the GPPCCC:

- Chronic Disease Management Working Group

- Medication Management Working Group
- Health Assessment Working Group
- Consultation item Working Group
- Referrals and Repeat Scripts Working Group

Details on the membership of the GPPCCC and the five working groups can be found at Appendix A.

4.2.3 General Practice and Primary Care Clinical Committee Recommendations (Phase 2)

Below are the recommendations from the GPPCCC Phase 2 report. The recommendations seek to better prioritise MBS and broader funding to support effective, longitudinal care for patients.

Vision for the Future – GP stewardship and team based care

Recommendation 1 – Move to a person-centred primary care model supporting GP stewardship and team based care

a. Challenges facing the Australian health system include an ageing population with a growing burden of chronic disease, increasing costs of interventions, unexplained variances in care delivery, inequities of access and outcome, missed opportunities for prevention, and a high proportion of avoidable hospital admissions by international standards.

b. There is strong evidence that high quality, person-centred primary health care is key to improving effectiveness of care, preventing illness, and reducing inequities, variation and costs. However, there is poor fit between fee-for-service reimbursement and primary health care that provides continuing care for the person rather than episodic treatment for illness; that emphasises prevention and health promotion in addition to disease management; that focuses on outcomes rather than process; and that provides collaborative team based care integrated into the larger health system (1; 2).

c. Noting the above, the findings from the Diabetes Care Project (3), and the recommendations from the Primary Health Care Advisory Group (4), the GPPCCC recommends that a new model for primary care funding should be developed to support high-quality, person-centred primary health care and GP stewardship of the health system that is supported by multidisciplinary team based arrangements. The GPPCCC defines person-centred care as “a way of thinking and doing things that sees the people using health services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome." (5)

d. These strategies to support person-centred care are particularly important at the interface between community, GP-care and acute hospital care.

Rationale 1

- Equitable access to high quality, person-centred health care is a fundamental human right, and an aspiration of the Australian health system.
- To achieve equitable access to high quality health care for all, our health system needs to pursue the four goals of the “quadruple aim” (6; 7):
    - maximising patient outcomes

- enhancing patient experience
- minimizing costs
- optimizing the experience of health providers

- The GPPCCC has identified principles for Australian primary care, based on review of key national and international statements and reports (8; 9; 10; 11).

Figure 9: GPPCCC Phase 2 – Principles for primary health

BASIC PRINCIPLES	1	First contact care
	2	"Gatekeeper" function providing stewardship of the health system
	3	Equitable access
	4	Care throughout the life-cycle, for persons, families, and communities
	5	Evidence based care, aiming at safety and effectiveness
	6	Comprehensive – whole person, biopsychosocial approach
	7	Team-based, coordinated care
	8	Continuing care, enduring relationships
	9	Person-centred, partnering with consumers
	10	Health promoting, incorporating a preventive focus
	11	Reflective practice with continuous quality improvement
	12	Sustainable
IMPLICATIONS	▪ Flexibility to meet the varying needs of consumers, communities and regions ▪ Access according to need ▪ Voluntary patient enrolment, supporting comprehensive, longitudinal care; linked to care planning and health assessments ▪ Person-centred care, promoting health literacy and partnering patients ▪ Multidisciplinary team-based care, recognising that team members may be both internal and external to the general practice ▪ Care coordination when needed ▪ Support for health promotion and disease prevention ▪ Digital systems to optimise care across the continuum of self-, primary-, and tertiary-care (MyHealth Record, care pathways, decision support, m-health etc.) and to enable reporting and feedback ▪ Support for reflective practice and continuous quality improvement, including research, innovation, teaching, and learning ▪ Adequate infrastructure and funding	

Elements of an Australian person-centred primary care model supporting GP stewardship and team based care

In Phase 1 of its work, the GPPCCC identified strategies to support GP stewardship and team based care. These complement the principles and implications identified in Figure 9 above and provide mechanisms for GP stewardship within the context of person-centred primary care.

Figure 10: GPPCCC Phase 2 – Elements of an Australian person-centred primary care model supporting GP stewardship and team based care

PRIMARY CARE MODEL CENTRED ON GP STEWARDSHIP	**1** Consumer interaction with the health system	Voluntary patient enrolment with a medical home, supporting comprehnsive, longtitudinal care and linked to care planning and health assessments.
		Effective systems to inform and sypport patients in obtaining best care for their needs
		Person-centred care, partnering with the patient and promoting health literacy, consumer empowered and self-management
	2 Health Professionals	Multidisciplinary team-based, co-ordinated care
		Capabilities of workforce fully utilised, -practice nurses, allied health professionals and others practicing at 'top of licence'
		Evidence-based care, delivering safety, effectiveness, health promotion and disease prevention
	3 System and processes	Digital support to optimise care across the health system (inlcuding MyHealth Record, care pathways, decision support, m-health)
		Support for reflective practice and continuous quality improvement, including research, innovation, teaching and learning
		Information sharing about performace with peer-comparison
	4 Financing	Sustainable infrastructure and funding to meet population health needs
		Flexible, blended funding model ensuring equitable access according to clinical need
		GP as the steward of the health system

GPPCCC Phase 2 Recommendation 1 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Voluntary Patient Enrolment – enhancing patient access

The GPPCCC supports the implementation of a VPE model that encourages practices to build continuity of care into their business models, ensuring support for longitudinal care and population health, as well as acute, episodic care.

Recommendation 2 – Introduce a new fee for practices to enrol a patient

a. The fee should be weighted by relevant patient characteristics, such as rurality, Indigeneity, risk, etc.

b. This fee supports the holistic care that practices and GPs deliver to enrolled patients through flexible access e.g. through non-face-to-face channels, communication of results, and repeat prescriptions or referrals where clinically appropriate. The mutual obligations on the GP and the practice ***for enrolled patients*** should at a minimum include the following:

   (i) Providing ***non face-to-face access*** to enrolled patients

   (ii) Providing ***some after hours or emergency services*** for enrolled patients

c. Consumers should be able to choose whether to enrol with a practice, and nominate a GP within that practice, with flexibility so patients can see other providers within the practice. The model would also need to maintain enrolled patient access to services outside of their nominated practice, such as where patients require urgent or emergency services or may be travelling.

d. The GPPCCC recommends that the Government engage with consumers (potentially through focus groups) to develop a clear outline of the patient's role in enrolment, and to develop appropriate language around formalising the relationship between the doctor and patient, noting the importance of informed patient consent.

e. This fee also supports Recommendation 1, including the need to better align the reimbursement model with the requirements of high quality, person-centred primary health care, GP stewardship of the health system, and continuous quality improvement.

f. For enrolled patients, chronic disease management and health assessment items should be restricted to those practices where a patient is enrolled. For patients who are not enrolled, these items can continue to be claimed by the patient's usual GP.

g. The nominated GP should be responsible for maintaining the patient's My Health Record, where the patient has not opted-out.

h. The GPPCCC recommends that there is broad consultation with consumers and health professionals on all recommendations, noting the potentially wide-ranging impact of this specific recommendation.

i. The GPPCCC notes the unique issues with enrolment which may be faced by patients in rural and remote areas, and for mobile populations, and recommends that appropriate flexibility should be built into the model to address these challenges.

Rationale 2

- Evidence indicates that having a regular GP is beneficial for patient outcomes (18), patient experience and value for the system (19; 20; 21; 22; 23).
- Patient enrolment will encourage practices to build continuity of care into their business models, ensuring support for longitudinal care and population health as well as acute, episodic care.
- GPs and practices will be remunerated for consultation through multiple channels, facilitating digitally enabled care where appropriate.
- Stronger connection between patient and the GP-led practice team can assist patients to navigate the health system and can ensure more seamless communication between primary and hospital care.
- Enrolment will lead to stronger GP stewardship, with GPs supported to drive data-driven improvements in quality of care, and in referral and prescribing practices leading to potential downstream savings from preventable hospitalisations.
- Weighting of the payment is necessary because there are various factors which will change the likely cost of caring for a patient holistically over a period of time, e.g. flexible-access needs are likely to be higher for rural practices.
- This will not require a major change to existing patient behaviour. A survey in 2012 reported that 92% of Australians always attend the same practice, however many see multiple GPs within that practice (24). A similar survey (25), in 2013, reported over one-quarter of the sample had attended more than one practice in the previous year. Multiple practice attendance was less common with increasing age, and less likely for survey respondents from regional Australia, compared with respondents from metropolitan areas.

GPPCCC Phase 2 Recommendation 2 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

The Taskforce notes that VPE is already supported by the Government with work underway to implement enrolment with GPs for people aged 70 years and over (and Aboriginal and Torres Strait Islander people aged 50 year and over).

Recommendation 3 – Introduce flexible access to primary care services for enrolled patients

a. The GPPCCC recognises that many members of the community including those living with disability and/or with transport issues, and people living in rural and remote communities, face challenges in attending general practices. This recommendation focuses on increasing access to care.

b. The mutual obligations on the GP and the practice for enrolled patients should at a minimum include the following:

   (i) Providing non-face-to-face access to enrolled patients

   (ii) Providing some after hours or emergency services for enrolled patients

c. If the recommendation on VPE is not supported, the GPPCCC recommends that flexible access including non-face-to-face access (e.g. telephone, email, video consulting, telehealth, etc.) for consumers facing difficulties in accessing face-to-face consultations (e.g. remote, rural, disabled) be made available as soon as possible through other means, including new MBS items.

Rationale 3

This recommendation focuses increasing access to care. It is based on the following:

- The evidence demonstrates high patient satisfaction and consumer support for non-face-to-face care (26)
- There is strong evidence that non-face-to-face care can increase access, without compromising patient outcomes (27; 28)
- There is strong stakeholder support for flexible access, including non-face-to-face access (see submissions from stakeholders to the GPPCCC)

GPPCCC Phase 2 Recommendation 3 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

The Taskforce notes this work should be about using non face-to-face services to support care within existing arrangements (i.e. GP stewardship) and should not be used to promote fragmentation of care. There should be a mechanism to enable non-face to face, non-real time interventions that improves patient care and the new arrangements should support this.

Chronic disease management – supporting coordinated, comprehensive and continuing care

Recommendation 4 – Implement a comprehensive package of longitudinal care for enrolled patients with chronic health conditions that promotes the effective use of primary care chronic disease management items

The GPPCCC recommends that a range of enhancements to MBS supported chronic disease management items to increase high value primary care, enhance multidisciplinary care planning and coordination activities, and support increased patient activation.

These enhancements represent an analogous package of care for patients with chronic health conditions and are not intended to be considered in isolation.

Recommendation 4.1 – Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs), and strengthen GPMPs

a. Delete item 723

b. Delete item 729

c. Do not change item 731

d. For item 721

(i) Change item descriptor, schedule fee and explanatory note

(ii) The descriptor should:

- State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
- Include the coordination of the development of team care arrangements where required.

(iii) The explanatory note should:

- Note that a GPMP should include an assessment of physical, psychological and social function, and should encompass a comprehensive preventive health plan (beyond the scope of existing chronic diseases),
- Note that the GPMP must address all the patient's known health care needs, health problems and other relevant conditions
- Include the requirement to review the patient's health record to ensure currency and accuracy
- Require the GPMP to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable
- Include a strengthened definition of chronic condition, being a condition that "requires a structured and holistic approach", with detailed guidance added to the explanatory note on what does and does not constitute a chronic condition.

(iv) The proposed new descriptor for item 721 is as follows:

> Attendance by a patient's usual GP and other health professionals in the practice where the patient is enrolled (or the usual practice for patients who are not enrolled), for preparation of a GP management

plan and to coordinate any necessary team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply).

(v) The proposed new explanatory note for item 721 is as follows:

This Chronic Disease Management (chronic disease management) service is for a patient who has at least one medical condition that:

a) has been (or is likely to be) present for at least six months and requires a structured, ongoing and holistic approach, or

is terminal.

A rebate will not be paid within twelve months of a previous claim for item 721, or within three months of a claim for item 732, except where there are exceptional circumstances that require the preparation of a new GPMP.

A comprehensive written plan covering management of the patient's chronic disease(s) and comprehensive preventive health plan must be prepared describing:

a) All the patient's known health care needs, health problems and other relevant conditions, including an assessment of physical, psychological and social function, and reviewing the patient's health summary to ensure currency and accuracy,

b) A comprehensive health promotion and disease prevention plan, agreed with the patient,

c) management goals with which the patient agrees,

d) actions to be taken by the patient,

e) treatment and services the patient is likely to need,

f) arrangements for providing this treatment and these services,

arrangements to review the plan by a date specified in the plan, and

g) if required, arrangements for multidisciplinary care of the patient, including treatment and service goals, treatment by other providers, and patient actions.

In preparing the plan, the provider must:

a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan, and

b) record the plan, and

c) record the patient's agreement to the preparation of the plan, and

d) offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees), and

e) add a copy of the plan to the patient's medical records, and upload a copy of the plan to My Health Record, unless patient consent is withdrawn, and where reasonably achievable, and

f) provide an appropriate written referral to collaborating providers with copies of relevant parts of the document attached, and advise that the document has been uploaded to My Health Record where appropriate.

Rationale 4.1

- This recommendation focuses on reducing administrative burden and low value care and increasing patient activation in their own care planning.
- The GPPCCC agreed that planned proactive health care is critical to patient outcomes.
    - Approximately 50% Australians have at least one prominent chronic health condition (i.e. arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or mental ill-health). Nearly a quarter of all Australians (23%) have two or more chronic conditions. Chronic conditions are responsible for around three-quarters of the total non-fatal burden of disease in Australia (29).
    - Aboriginal and Torres Strait Islander people experience poorer health than other Australians, with a burden of disease 2-3 times greater than the general Australian population. Much of the difference is due to chronic conditions (30). Chronic disease is also a major cause of higher morbidity and mortality in remote and rural areas, and in economically disadvantaged communities.
    - The World Health Organization (WHO) argues that in order to respond to the emerging epidemic of chronic, non-communicable disease and the growing costs of referred care, health services need to develop as integrated, person-centred health systems, founded on strong, coordinated and well-resourced primary health care (31; 32).
    - Essential elements of integrated care of patients living with chronic disease include (33; 34; 35; 36):
        - Person-centredness, including personal goal setting, empowerment, activation and education
        - Evidence-based treatment that is safe and effective
        - Proactive care with a focus on prevention (primary, secondary, tertiary)
        - Continuity of care with availability of health information as & when required
        - Individualized care planning and regular reviews
        - Flexible, multi-disciplinary team-based care
        - Care facilitation for those who require it
        - Equitable and timely access to care
        - Continuous quality improvement
    - Person-centredness is the clinical method used by the GP to effectively incorporate patient experience and expectations into the clinical care (37; 38). This approach incorporates and facilitates empowerment goal setting and engagement by the patient in their health concern. The method used as a standard approach in all consultations leads to a more collaborative approach to patient concerns and health care.
    - An evidence review by McKinsey reported significant reductions in hospitalization rates from patient empowerment and education, multidisciplinary team care, care coordination, and individualized care plans (39).
    - The Australian Diabetes Care Project found statistically significant improvement in HbA1c, blood pressure and other key clinical variables, and reduced hospital costs, from an intervention

comprising an integrated information platform, data-driven CQI, funding based on risk stratification, QI support payments and dedicated Care Facilitators (40).

- The GPPCCC agreed that GPMPs and TCAs should be combined into one item to reduce administrative burden and reduce duplication.
    - There is strong support from AMA and other stakeholders to reduce administrative burden and red tape for chronic disease management items.
    - The majority of GPMPs and TCAs are currently claimed together (41):
        - 77% of GPMPs are co-claimed with TCAs in the same appointment, an increase from 37% in 2005-06.
        - 62% of GPMP and TCA reviews are co-claimed.
    - Some TCAs are claimed for patients who do not use the associated allied health services: 30% of patients who claimed a TCA did not use any allied health services that calendar year (42).
- The GPPCCC agreed that item 729 should be abolished as its usefulness is limited.
    - item 729 was only used 2574 times in 2016-17 (43).
- The GPPCCC agreed that there should be no change to item 731 as in the context of RACFs, an item for contributing to a care plan is more appropriate.
    - item 731 was used 131,935 times in 2016-17 (44).
- The GPPCCC agreed that a copy of the GPMP is to be uploaded to the My Health Record (unless patient consent is withdrawn, and where reasonably achievable) to assist in information sharing between the patient and their care team.
    - There should be exemptions for patients who have opted-out of My Health Record and for GPs and practices where it is not reasonably achievable e.g. with insufficient access to high-speed internet.

Recommendation 4.2 – Link allied health chronic disease management items to the creation of a GPMP

Change the descriptors for items 10950-10970 and 81100-81125 to remove references to TCAs and make clear that allied health services will be linked to the creation of a GPMP.

Rationale 4.2

This recommendation focuses on simplifying chronic disease management items. It is based on the following:

- The GPPCCC agreed that allied health items should be directly linked to the creation of a GP Management Plan, and the item for TCAs should be deleted.
    - 77% of GPMPs are co-claimed with TCAs in the same appointment, an increase from 37% in 2005-06 (41).
    - 30% of patients who claimed a TCA did not use any allied health services that calendar year (42).

Recommendation 4.3 – Equalise rebates for GPMP preparation and review to encourage longitudinal patient care

For item 732, change the descriptor, explanatory note and schedule fee

a. The schedule fee for items 732 and 721 should be of equal value, noting that the recommendations support an increase to funding for general practice, including chronic disease management.

b. The descriptor should:

   (i) State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.

   (ii) Specify that a 732 is only available 3 months after the creation of a 721, then every 3 months, with a maximum of three claims for item 732 in the first year and four claims in subsequent years. Note that an alternative is that after the creation of a 721, up to four 732s are performed a year without the need for further 721s. The GPPCCC supports either option, noting that this is primarily an administrative issue.

c. The proposed new descriptor is as follows:

- Attendance by a patient's usual GP at the practice where the patient is enrolled (or the usual practice for patients who are not enrolled) to undertake a comprehensive review of a GP Management Plan prepared by a GP to which item 721 applies, and to coordinate any necessary team care arrangements.
- Each service to which item 732 applies may only be claimed after three months has passed from the creation of the GP Management Plan (item 721), and then every three months up to a maximum of three claims in the first year and four claims in subsequent years, except where there are exceptional circumstances that necessitate earlier performance of the service to the patient.

d. The explanatory note should specify that any changes in the Care Plan triggered by the review should be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

e. The proposed new explanatory note is as follows:

When reviewing a GP Management Plan, the medical practitioner must:

a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review,

b) record the patient's agreement to the review of the plan,

c) review all the matters set out in the relevant plan,

d) make any required amendments to the patient's plan and add any new clinically relevant conditions as needed,

e) offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees),

f) provide for further review of the amended plan by a date specified in the plan,

g) add a copy of the plan to the patient's medical records, and if the plan is amended upload a copy of the amended plan to My Health Record, unless patient consent is withdrawn and where reasonably achievable, and

h) provide copies of relevant parts of the document or advise that the document has been uploaded to My Health Record in referrals to collaborating providers.

For item 721

a. The schedule fee for items 721 and 732 should be of equal value, noting that the recommendations support an increase to funding for general practice, including chronic disease management.

Rationale 4.3

This recommendation focuses on improving access to longitudinal care for patients with chronic disease and ensuring proper use of chronic disease management items. It is based on the following.

- The GPPCCC agreed that increased use of item 732 would deliver increased longitudinal care for patients with chronic disease.
    - Longitudinal care and reviewing and updating the plan by the patient's usual GP is important in optimising patient outcomes from chronic disease management planning (45).
    - 55% of patients with GPMPs did not receive a review within a year in 2016/17 (46).
    - Reviews are currently reimbursed at around half the schedule fee of the creation of a GPMP.
- The GPPCCC agreed that the quality of item 732 would be strengthened by ensuring that it is conducted by a GP at the practice where the patient is enrolled and requiring the updated plan to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
    - Requiring the review to be conducted by a GP at the practice where the patient is enrolled will ensure that the review is facilitating longitudinal care.
    - Requiring the updated plan to be uploaded to My Health Record will enable patient and the patient's other health care providers to access the current plan.

Recommendation 4.4 – Increase patient access to high quality care coordination across physical, mental and social care domains

Rationale 4.4

This recommendation focuses on increasing access to care coordination services that encompass bio-psycho-social models of care and supports active patient involvement in their own care planning. It is based on the following:

- Consumers report difficulty with care navigation, including limited information and choice for patients about cost, quality and availability.
- Consumers with complex health care needs would benefit from greater assistance with care coordination and navigation from a registered nurse, enrolled nurse or Aboriginal health practitioner or Aboriginal health worker.

Recommendation 4.5 – Develop advice and support mechanisms to activate and engage patients in their own care planning, including the assessment and support of patient health literacy activities

Rationale 4.5

This recommendation focuses on improving patient experience and increasing patient activation in care planning.

The GPPCCC agreed that patients need to be more involved in their own care planning, including:

- effective care coordination means actively involving the patient in goal setting and decision-making, and providing self-management support (47), and
- clinical experience suggests that patients may not be sufficiently supported or engaged in their own care planning.

Recommendation 4.6 – Encourage increased patient participation and rebate attendance of non-medical health professionals at case conferences

For items 735, 739, 743, 747, 750

a. Change the explanatory note to:

   (i) Specify that the patient or their nominated representative should usually be invited to attend the case conference, subject to patient agreement,

   (ii) Require the GP to provide a summary of the conference to the participants and to upload the updated care plan if changed by the case conference to My Health Record, unless patient consent is withdrawn, and where reasonably achievable,

   (iii) Note that case conferences can take place via telephone.

   (iv) State that these items are available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.

b. The proposed new explanatory note is as follows:

> Items 735 to 758 provide rebates for GPs to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.
>
> To organise and coordinate case conference items 735, 739 and 743, the provider must:
>
> a) explain to the patient the nature of a multidisciplinary case conference, ask the patient for their agreement to the conference taking place, and ask the patient if they would like to attend the case conference (unless there is a valid clinical reason why the patient should not attend, which must be documented), and
>
> b) record the patient's agreement to the conference, and
>
> c) record the day on which the conference was held, and the times at which the conference started and ended, and
>
> d) record the names of the participants, and

e) offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members, and

f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees), and

g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records, and upload to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

To participate in multidisciplinary case conference items 747, 750 and 758, the provider must:

h) explain to the patient the nature of a multidisciplinary case conference, ask the patient for their agreement to the conference taking place, and ask the patient if they would like to attend the case conference, and

i) record the patient's agreement to the GP's participation, and

j) record the day on which the conference was held, and the times at which the conference started and ended, and

k) record the names of the participants, and

l) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records, and upload to My Health Record any consequential changes to the Care Plan, unless patient consent is withdrawn and where reasonably achievable.

Usual GP

- items 735-758 should generally be undertaken by the patient's usual GP. This is the patient's nominated GP, or a GP working in the medical practice where the patient is enrolled. For patients who are not enrolled, the usual GP is the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months.

Multidisciplinary case conference team members

- Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are Nurse practitioners and allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.
- A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.
- The patient's informal or family carer may be included as a member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Discharge case conference

- Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital.

c. Create three new items to rebate attendance at a case conference by non-medical health practitioners, one for 15-20 minutes to align with item 747, and one for 20-40 minutes to align with item 750, and one for >40 minutes to align with item 758.

d. The first proposed new descriptor is as follows:

Attendance by a health practitioner (including allied health professionals, registered nurses and nurse practitioners, but not including a GP, specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in:

a) a community case conference, or

b) a multidisciplinary case conference in a residential aged care facility, or

c) a multidisciplinary discharge case conference,

if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply).

e. The second proposed new descriptor is as follows:

Attendance by a health practitioner (including allied health professionals, registered nurses and nurse practitioners, but not including a GP, specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in:

a) a community case conference, or

b) a multidisciplinary case conference in a residential aged care facility, or

c) a multidisciplinary discharge case conference

if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply).

f. The third proposed new descriptor is as follows:

Attendance by a health practitioner (including allied health professionals, registered nurses and nurse practitioners, but not including a GP, specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in:

a) a community case conference, or

b) a multidisciplinary case conference in a residential aged care facility, or

c) a multidisciplinary discharge case conference

if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply).

Rationale 4.6

This recommendation focuses on improving access to case conferencing as part of effective chronic disease management, and ensuring that the patient is engaged in their own care planning. It is based on the following:

- The GPPCCC agreed that use of case conferencing was important:
    - Approximately 50% Australians have at least one prominent chronic condition (i.e. arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or mental ill-health) (48)
    - Multi-disciplinary team based care, with efficient and accurate communication between providers, is essential for the safe and effective care of patients living with chronic disease (49; 50; 51). This was one of the elements identified by McKinsey in an evidence review as providing significant reductions in hospitalization rates (52).
    - While much communication between providers is appropriately written, verbal communication can complement this and is widely seen as essential for safety and quality in chronic disease management (53; 54; 55).
- The GPPCCC agreed that uptake of case conferencing items is variable
    - The number of GP case conferencing items per 1000 population varies widely across States and Territories (highest in the Northern Territory (NT), lowest in South Australia (SA), a 4.4-fold difference). Rates are also significantly higher in remote and rural communities. Rates are highest in patients aged 70 years and older (56).
    - GPs report that it is logistically difficult to arrange a face to face or teleconference meeting with at least two other providers, and that the requirement for contemporaneity makes inclusion of additional members even more challenging.
- The GPPCCC agreed that patients should be given the opportunity to participate in case conferences
    - Consumers report limited awareness of these items' availability.
    - Effective care coordination means actively involving the patient in goal setting and decision-making, and providing self-management support
- The GPPCCC agreed that enabling non-doctor health practitioners to claim an MBS item for participation in a case conference may increase uptake of case conferences
    - Multi-disciplinary team based care, with efficient and accurate communication between providers, is essential for the safe and effective care of patients living with chronic disease.
    - While much communication between providers is appropriately written, verbal communication can complement this and is widely seen as essential for safety and quality in chronic disease management.
    - Case conferencing items are not highly utilised, with 3.5 services per 1000 patients, but their use is growing (15% compound annual growth (CAGR)) (57).

Recommendation 4.7 – Link Medication Management Reviews (MMR) to GPMP and ensure the rebate accurately reflects GP activity

For item 900, change the descriptor, explanatory note and schedule fee.

a. The descriptor should:

   (i) Specify that the item can be claimed at the same time or within 12 months of a GPMP or review (item 721), for a patient at risk of medication misadventure due to unstable health status, use of high risk medicines, not meeting therapeutic goals, or issues surrounding adherence.

   (ii) State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.

   (iii) Require a copy of the DMMR to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

b. The proposed new descriptor for item 900 is as follows:

> Participation by a patient's usual GP at the practice where the patient is enrolled (or the usual practice where a patient is not enrolled) in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the GP, or their proxy, with the patient's consent:
>
> a) assesses the patient as:
>
> (i) having a GP Management Plan (GPMP) or review which was created in the last 12 months, and
>
> (ii) being at risk of medication misadventure due to unstable health status, use of high risk medicines, or issues surrounding adherence, and
>
> (iii) not having their therapeutic goals met, and
>
> b) following that assessment:
>
> (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR, and
>
> (ii) provides relevant clinical information required for the DMMR, and
>
> (iii) reviews the pharmacists report from the DMMR including suggested medication management strategies, and
>
> (iv) updates the medication management section of the GPMP following discussion with the patient, and
>
> (v) uploads the current medication management plan to My Health Record, unless patient consent is withdrawn and where reasonably achievable.
>
> For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.
>
> A proxy can request a medication review only if they:
>
> 1. seek and receive consent from the patient's usual GP who will complete the DMMR, and
>
> 2. are a hospital doctor or senior hospital staff member caring for patient being discharged, or are a remote area nurse or aboriginal health practitioner where the patient is located in MMM5, 6 or 7.

c. The explanatory note should allow appropriately trained allied health professionals to assist with information gathering that would allow an accredited pharmacist to complete the DMMR without being physically present, for use in very remote communities where timely access to an accredited pharmacist is not feasible.

d. The schedule fee should be substantially reduced, and any savings should be re-invested into other initiatives to support general practice such as VPE.

e. The proposed new explanatory note for item 900 is as follows:

A Domiciliary Medication Management Review (DMMR) (item 900), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

DMMR's are targeted at patients who are:

a) currently taking five or more regular medications or taking more than 12 doses of medication per day, and

b) have had significant changes made to medication treatment regimen in the last three months, or

c) taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring, or

d) experiencing symptoms suggestive of an adverse drug reaction, or

e) displaying sub-optimal response to treatment with medicines, or

f) suspected of non-compliance or inability to manage medication related therapeutic devices, or

g) having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties, or

h) attending a number of different doctors, both GPs and specialists, or

i) recently discharged from a facility / hospital (in the last four weeks).

In referring a patient for a DMMR, GPs should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

a) Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card,

b) Is subject to a chronic condition and/or complex medication regimen, and

c) Is failing to respond to treatment in the expected manner.

If the patient does not meet these criteria, the GP can still issue a referral under this item. However, the remainder of the service will be on a "user pays" basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a GP must, with the patient's consent:

a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met, and

b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review, and

c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies, and

d) develop a written medication management plan following discussion with the patient, and

e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

In the case of very remote communities where a visit from an accredited pharmacist is unlikely, the home visit may be conducted by a suitably trained remote area nurse or aboriginal health practitioner who will act on behalf of the centrally located accredited pharmacist completing the DMMR.

Claiming

A DMMR includes all DMMR-related services provided by the GP from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review, only item 900 may be claimed.

If the GP determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the GP (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE

A DMMR should generally be undertaken by the patient's usual GP. For a patient who is enrolled, this is a GP in the practice where a patient is enrolled. For a patient who is not enrolled, this is the GP, or a GP working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the GP in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of referral to a community pharmacy or an accredited pharmacist includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred, and
- Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the GP for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.
- A DMMR referral form is available for this purpose. If this form is not used, the GP must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.
- The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes:

a) Receiving a written report from the reviewing pharmacist, and

b) Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face), and

c) Developing a summary of the relevant review findings as part of the draft medication management plan.

- Development of a written medication management plan following discussion with the patient includes:

a) Developing a draft medication management plan to be incorporated into patient’s GPMP and discussing this with the patient, and

b) Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist and uploaded to My Health Record.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

For item 903, change the descriptor and schedule fee.

a. The descriptor should:

(i) state that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled, and

(ii) require a copy of the RMMR to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable, and

(iii) allow a proxy to request a medication review where they have sought consent from the patient's usual GP, and where the patient is either being discharged or lives in MMM 5, 6, or 7.

b. The schedule fee should be substantially reduced to make it equal to item 900, noting that any savings should be re-invested into other initiatives to support general practice such as VPE.

c. The proposed new descriptor for item 903 is as follows:

> Participation by a patient's usual GP in the practice where a patient is enrolled (or the usual practice for a patient who is not enrolled) in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility-other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR.
>
> The RMMR should result in an update to the resident's medication management plan and the current medication management plan should be uploaded to My Health Record, unless patient consent is withdrawn and where reasonably achievable.

Rationale 4.7

This recommendation focuses on better targeted MMRs and ensuring that the rebate accurately reflects the practitioner's effort.

- The GPPCCC agreed that item 900 should be limited to those patients who have had a GP Management Plan or review performed in the last 12 months.
    - DMMRs have the greatest benefit for patients with chronic diseases or on complex medication regimes (58; 59).
    - 72% of patients with a DMMR have a GPMP initiated within a year of their medication review.
    - The item descriptor for item 900 includes significant overlap with GPMPs.
- The GPPCCC agreed that the schedule fee for items 900 and 903 should be substantially reduced.
    - The current rebate for item 900 is $154.60 and for item 903 is $106.00 compared with $144.25 for item 721.
    - item 900 will likely be performed in conjunction with a GPMP or a review of a GPMP.
- The GPPCCC agreed that the descriptor should reflect risk of medication misadventure
    - The descriptor previously required the patient to have a chronic medical condition or a complex medication regimen
    - Linking item 900 to GPMPs will mean that most patients have a chronic medical condition
    - There are some patients with a complex medication regimen who may not be at risk of medication misadventure

- The GPPCCC agreed that the MMR should trigger the upload of a current medication management plan to My Health Record, unless patient consent is withdrawn and where reasonably achievable, to facilitate increased patient awareness and data sharing between health practitioners
- The GPPCCC agreed that access to MMRs should be improved for patients in rural and remote areas, and for patients who are being discharged from hospital
    - There is significant geographical variation in MMR claiming patterns, with overall claims 3.4 times higher in New South Wales (NSW) compared with NT.

Recommendation 4.8 – Increase the scheduled fee for home visits for enrolled patients

For items 24, 37 and 47, increase the schedule fee for a home visit for patient when attended by a GP from the practice where the patient is enrolled.

Rationale 4.8

This recommendation focuses on increasing support for home visits for patients who are enrolled within a practice. It is based on the following:

- With an ageing population, it is important to facilitate people who want to stay in their homes.
- Extension of higher rebates to all patients could have unintended consequences similar to those experienced in urgent after-hours care (60).

GPPCCC Phase 2 Recommendation 4 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Health Assessment items - better alignment with need and evidence

Recommendation 5 – Build the evidence base for health assessments and ensure that the content of health assessments conforms to appropriate clinical practice guidelines

The GPPCCC recommends that a process be established to gather evidence on the effectiveness and frequency of health assessments with a focus on at-risk populations, including using data at a PHN level based on existing groups eligible for health assessments, and commissioning studies on the evidence for health assessments for new at-risk groups.

Rationale 5

This recommendation focuses on increasing the evidence base for health assessments to ensure that preventative care is delivered in the most effective way. It is based on the following:

- The GPPCCC agreed that there is limited evidence around health assessments
    - The Hereco literature review commissioned by the GPPCCC found evidence for health assessments in certain populations:
        - Persons with intellectual disability: There is substantial evidence to suggest that health assessments lead to detection of unmet needs, which leads to increases in activities conducive to better health outcomes, can prevent disease in people with intellectual disability, and can reduce preventable emergency admission (61; 62; 63).

- There is evidence that annual health checking is justifiable, with a similar number of new health problems found at the repeat check compared to the initial check (64).
- Persons over the age of 75: A systematic review found that the majority of "more methodologically sound studies" were found to report improvements in health but the review found no evidence that targeting of the frail elderly enhanced outcomes (65).
- Persons over the age of 65: One RCT focused on people 65+ found a mean decline in health status was 2% lower in intervention group than control group, and death rate was significantly lower in intervention than control (8.3% vs 11.1%). No differences were observed in changes in health behaviours (66).

- However, there was limited evidence found for health assessments in the general population or other populations:
  - Health checks led to an overall increase in the number of new diagnoses and more treatment (67), and lessened patient worry (68), but did not improve morbidity or mortality, leading most studies to conclude that health checks on the general population are not warranted (67; 69).
  - There is some evidence that cardiovascular disease (CVD) systematic risk assessment may have favourable effects on CVD risk factors, but not enough to justify introduction of general screening (70; 71).

GPPCCC Phase 2 Recommendation 5 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Recommendation 6 – Introduce a 6 minute minimum time for a Level B consultation item

For items 23, 5020 and 5023:

a. change the descriptors to state that the consultation length should be a minimum of 6 minutes,

b. the new descriptor for item 23 should be as follows:

> Professional attendance by a GP (not being a service to which any other item in this table applies) lasting at least 6 minutes and less than 20 minutes, including any of the following that are clinically relevant:
>
> a) taking a patient history,
>
> b) performing a clinical examination,
>
> c) arranging any necessary investigation,
>
> d) implementing a management plan, and/or
>
> e) providing appropriate preventive health care,
>
> in relation to 1 or more health-related issues, with appropriate documentation.

and

c. the descriptors for item 5020 and 5023 should be similarly amended to reflect a time of at least 6 minutes and less than 20 minutes

Note: there was dissent from a number of GPPCCC members on this recommendation.

Rationale 6

This recommendation focuses on ensuring high value care and consistency across items. It is based on the following.

- Consultations less than 6 minutes may not always constitute high value care but may be sufficient for issues including repeat scripts and referrals, vaccinations, etc. (especially within the context of an ongoing relationship between the GP and patient)
- The Level A item enables GPs to bill for care provided in less than 6 minutes
- The system should create incentives for GPs to provide higher value care, and any spend reduction should therefore be reinvested either in the Level A-D consultation rebate or in VPE.

GPPCCC Phase 2 Recommendation 6 – Endorsed (with amendment) for Government consideration

The Taskforce notes that the GPPCCC received feedback opposing this recommendation during the public consultation on this report, and did not express a consensus view on whether to keep or remove this recommendation. The Taskforce discussed this recommendation and on the basis of the rationale provided by the GPPCCC in their draft Report agreed to endorse this recommendation noting that the appropriate minimum time for a Level B consultation will require further discussion.

The Taskforce further noted this recommendation is consistent with the structure for time-tiered attendances for specialists and consultant physician MBS items, as recommended in the Specialist and Consultant Physician Clinical Committee report.

Recommendation 7 – Strengthen the quality of current health assessments and expand at-risk groups who are eligible for health assessments

For items 701, 703, 705 and 707, change the descriptors and explanatory notes

a. The descriptors should:

   (i) State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.

   (ii) Include the requirement that the GP must personally explain the findings and implications of the health assessment to the patient and agree with the patient a plan for health promotion and disease prevention based on these findings.

   (iii) Include the requirement that the health assessment be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

b. The proposed new descriptor for item 703 is as follows:

Professional attendance by a patient's usual GP at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including:

a) detailed information collection, including taking a patient history, and

b) an extensive physical examination, and

c) initiating interventions and referrals as indicated, and

d) providing a preventive health care strategy for the patient.

The GP must personally explain the findings and implications of the health assessment to the patient and agree with the patient a plan for health promotion and disease prevention based on these findings.

The health care strategy must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

c. The proposed new descriptor for item 705 is as follows:

Professional attendance by a patient's usual GP at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including:

a) comprehensive information collection, including taking a patient history, and

b) an extensive examination of the patient's medical condition and physical function, and

c) initiating interventions and referrals as indicated, and

d) providing a basic preventive health care management plan for the patient.

The GP must personally explain the findings and implications of the health assessment to the patient and agree with the patient a plan for health promotion and disease prevention based on these findings.

The health care management plan must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

d. The proposed new descriptor for item 707 is as follows:

Professional attendance by a patient's usual GP at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) to perform a prolonged health assessment (lasting at least 60 minutes) including:

a) comprehensive information collection, including taking a patient history, and

b) an extensive examination of the patient's medical condition, and physical, psychological and social function, and

c) initiating interventions or referrals as indicated, and

d) providing a comprehensive preventive health care management plan for the patient.

The GP must personally explain the findings and implications of the health assessment to the patient and agree with the patient a plan for health promotion and disease prevention based on these findings.

The comprehensive health care management plan must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

e. The explanatory notes should:

(i) Expand eligibility of health assessments to new at-risk populations and modify existing populations to better align with clinical and service needs.

(ii) Ensure that the content of health assessments should conform to guidelines generally acceptable to the wider body of the profession such as the Guidelines for preventive activities in general practice 9th edition (Red Book) or future editions where appropriate.

f. The proposed new explanatory note for items 703, 705 and 707 is as follows:

There are three time-based health assessment items, consisting of standard, long and prolonged consultations.

Standard health assessment (MBS item 703)

A standard health assessment is used for straightforward assessments lasting 30-45 minutes.

Long health assessment (MBS item 705)

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged health assessment (MBS item 707)

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

General practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

MBS items 703, 705 and 707 may be used to undertake a health assessment for the following target groups:

Target Group	Frequency of Service
A health assessment for people aged 40-49 years (inclusive) who are at risk of developing chronic disease including type 2 diabetes	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A health assessment for people aged 75 years and older where the medical practitioner judges there is a safety risk in the home	Provided annually to eligible patients in the home, including an additional loading
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided on admission and annually to an eligible patient
A health assessment for people with a severe intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient

A health assessment for children in out-of-home care	Provided annually to an eligible patient
A health assessment for prisoners within three months of discharge from prison following a sentence of at least six months.	Once only following each period of imprisonment

A health assessment means the assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment must include the following elements:

a) information collection, including taking a patient history and undertaking or arranging examinations and investigations as required,

b) making an overall assessment of the patient,

c) recommending appropriate interventions,

d) providing advice and information to the patient,

e) keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment, and

f) offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

A health assessment may only be claimed for services provided by a medical practitioner (including a GP but not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the patient's nominated medical practitioner, or a medical practitioner working in the practice where the patient is enrolled. Where a patient is not enrolled, 'usual doctor' means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months.

MBS health assessment items, 703, 705, 707 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as registered or enrolled nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection, and

- providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (i.e. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

items, 703, 705 and 707 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 703, 705 and 707 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.

For item 715, change the descriptor and explanatory note

a. The descriptor should:

   (i) state that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled,

   (ii) include the requirement that the GP must spend a reasonable time reviewing the health assessment with the patient, and

   (iii) Include the requirement that the health assessment be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

b. The explanatory note should

   (i) include the requirement that the health assessment be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable, and

   (ii) the explanatory note should refer to guidelines generally acceptable to the wider body of the profession such as the Guidelines for preventive activities in general practice 9th edition (Red Book) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people, or future editions where appropriate.

c. The proposed new descriptor for item 715 is as follows:

Professional attendance by a patient's usual GP at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent-not more than once in a 9 month period.

The GP must personally explain the findings and implications of the health assessment to the patient and agree with the patient a plan for health promotion and disease prevention based on these findings.

The health assessment must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

Rationale 7

This recommendation focuses on improving the quality of health assessments and expanding eligibility to at-risk populations. It is based on the following:

- The GPPCCC agreed that health assessment requirement should reflect Guidelines for preventive activities in general practice 9th edition (Red Book) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people.
    - The Guidelines for preventive activities in general practice 9th edition (Red Book) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people provide the most up to data summation of evidence for preventative activities at each stage of a person's life.
- The GPPCCC agreed that health assessment eligibility should be expanded to certain at-risk populations:
    - Children in out-of-home care (annually).
        - A health assessment for children in out-of-home-care is in line with a number of strategies in place to improve the quality of care provided for children and young people in out-of-home care. As part of the National Framework for Protecting Australia's Children 2009-2020, the National Standards for Out-of-Home Care (2011) (72) were developed and endorsed by all States and Territories. These standards aim to drive greater consistency and improve the quality of care provided to children and young people. Standard five requires that children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended in a timely way.
        - To support achievement of standard five and to streamline services available, the National Clinical Assessment Framework - Children and Young People in Out-of-Home Care (73) was established by the DoH in 2011. The Framework outlines a best practice approach, highlighting GP participation as primary to establishing continuity of care for children and young people in out-of-home care. It has been endorsed by the Commonwealth; however, it has not yet been fully adopted in any of the States or Territories. The introduction of a dedicated MBS item would directly support clinical assessments of children and young people in out-of-home care and is in line with the Framework. This includes supporting Child Protection agencies and other stakeholders to have a common framework to contribute to the assessment.
        - The 2013 ACIL Allen Consulting report, health assessments and Interventions for Children and Young people in the Child Protection System, shows that this group also have poorer historical engagement with the health system and poorer health records (74).
    - Prisoners on discharge from prison (once following each episode of imprisonment for six or more months).
        - Availability of a structured, funded health assessment item would support former prisoners' access to primary care, and the assessment and management of their healthcare needs, with likely benefits for their own health, for population health (through the detection and management of infectious diseases), and possibly reducing re-offending.
        - Many people in prison and youth detention suffer poor health, often with their needs incompletely met. Mental disorders and infectious diseases are more common in prisoners than

in the general population. High rates of suicide within prison and increased mortality from all causes on release have been documented in many countries (75). Amongst women released from prison in NSW, 49% were on psychotropic medication and most required ongoing management for: mental health (71%), substance misuse (65%) and physical health (61%) problems (76).

- Former prisoners are at high risk of preventable morbidity and mortality following discharge. In a NSW study, in the first 12 months following discharge, all-cause SMR was 3.7 in men and 7.8 in women. The excess mortality was due to all major causes and was even higher in Aboriginal men and women (77). A Queensland data-linkage study concluded that "Young people are at markedly increased risk of death after release from prison and the majority of deaths are preventable" (78).
- However, there is poor transfer of care from prison to community (79).
- Barriers include both structural problems, and former prisoners' perception of GPs' unwillingness to care for prisoners. Consequently, former prisoners may not seek care, or their needs may not be fully assessed and met (80; 81; 82).
- Engagement with general practice after release increases health service utilization, enabling health promotion and disease management, and may reduce recidivism. An observational study in Queensland showed that early primary care physician contact was positively associated with mental health, alcohol and other drug treatment, and with subsequent primary care physician service utilisation over 6 months of follow-up (83). Another study showed that re-offending was reduced in former prisoners who had a family doctor, had good general health, were not depressed, had good nutritional health, and were not using cannabis or cocaine (84).

- The GPPCCC agreed that health assessment eligibility should be modified to better align with clinical and service needs:
  - Home visits for over 75 with a safety risk (annually)
  - 40-49 at risk of chronic disease (once)
  - RACF on admission and annually

GPPCCC Phase 2 Recommendation 7 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Consultation items - aligning consultation items with contemporary healthcare

Recommendation 8 – Undertake additional research regarding the appropriateness of the current length, content and minimum quality metrics for GP MBS consultation items (Level A-D)

Rationale 8

This recommendation focuses on increasing high value care. It is based on the following.

- The system should create incentives for GPs to provide higher value care and the development of a sophisticated set of metrics could be used to gauge the quality of consultation.
- Short consultations may not always constitute high value care but may be sufficient for issues including repeat scripts and referrals, vaccinations, etc. (especially within the context of an ongoing relationship

between the GP and patient). Additional research, including the time intersect between consultation items can be used to guide appropriate changes to the Level A-D consultation rebate or in VPE.

GPPCCC Phase 2 Recommendation 8 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Recommendation 9 – Introduce a new Level E consultation item for consultations of 60 minutes or more by a GP

a. The new descriptor should be as follows:

Professional attendance by a GP at consulting rooms (other than a service to which another item in the table applies), lasting at least 60 minutes and including any of the following that are clinically relevant:

a) taking an extensive patient history,

b) performing a clinical examination,

c) arranging any necessary investigation,

d) implementing a management plan,

e) providing appropriate preventive health care,

for one or more health-related issues, with appropriate documentation-each attendance.

and

b. the new schedule fee should have the same per-minute rate as a Level D consultation.

Rationale 9

This recommendation focuses on increasing support for long consultation where they are required. It is based on the following:

- There are some limited circumstances where a consultation of 60 minutes or more may be appropriate.
- GPs should be appropriately compensated for the time spent with patients.

GPPCCC Phase 2 Recommendation 9 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Recommendation 10 – Change the schedule fee for attendances at Residential Aged Care Facilities (RACF) to reflect an initial flag fall rebate with a stable fee for each consultation completed at the RACF

For items 20, 35,43, 51, 92, 93, 95 and 96, change the schedule fee to reflect an initial flag fall rebate for attendance at a RACF, with a stable fee for each consultation completed at the RACF (irrespective of the number of consultations).

Rationale 10

This recommendation focuses on increasing access to RACFs and addressing stakeholder concerns. It is based on the following.

- There does not appear to be an access issue for patients in RACFs
    - All consultations (including after hours) in RACFs increased from 15 per resident in 2009/10 to 23 per resident in 2016/17 (85)
    - 2008 and 2012 AMA surveys suggest an average time of around 16 minutes per patient (86)
    - There is a very strong correlation between the population in regional and remote areas and the percentage of total RACF services in 2016-17
- The number of GPs visiting RACFs has increased over the last 10 years
    - 37% of GPs visited RACFs in 2016/17 – 13,379 out of a total 35,9421. The number of providers performing level B consults in RACFs increased annually by 1.2% between 2006-07 and 2016-17 (87)
- However, stakeholders expressed concern at the current structure of fees, noting the unpredictability and the difficulties with privately billing patients where appropriate (see stakeholder submissions to GPPCCC).
    - On this basis the GPPCCC agreed that the fee calculations should be restructured, without a significant change in the overall rebates.

GPPCCC Phase 2 Recommendation 10 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

However, the Taskforce notes recent work to simplify claims for RACF services has rendered the items relevant to this recommendation obsolete. In March 2019, the derived fee model – a sliding scale related to the number of patients seen – used for items 20, 35, 43, 51, 92, 93, 95 and 96 was replaced with a call-out fee to cover doctors' costs of travel to a RACF (items 90001 and 90002) and new standard Level A to D attendance items were created (items 90020, 90035, 90043, 90051, 90092, 90093, 90095, 90096, 90183, 90188, 90202, 90212).

Consideration of the changes proposed within this recommendation should be transferred to the new item numbers.

Other recommendations

Recommendation 11 – Modernise the terminology currently used in the MBS to describe registered and enrolled nurses and their role to reflect the important role these health professionals play as members of the practice team

Rationale 11

- The term 'practice nurse' conflates the distinct groups of registered nurses and enrolled nurses.
- The language of 'for and on behalf of' does not appropriately reflect the role played by registered and enrolled nurses.

GPPCCC Phase 2 Recommendation 11 – Endorsed for Government consideration

The Taskforce supports this recommendation and the GPPCCC's rationale.

Recommendation 12 – Enable GP telehealth consultations and expand GP telehealth eligibility to patients with mobility concerns who cannot easily be seen face-to-face

The GPPCCC recommends that the descriptors of items 99 and 82220-82222 be expanded to make GPs eligible to provide a telehealth consultation, in addition to other specialists and consultants. Provision of these GP telehealth services should be restricted to a patient's usual provider.

The GPPCCC recommends that new items be created to reimburse GPs for their time for telehealth consultations (similar to items which currently exist to reimburse other specialists) to support Nurse practitioners and Aboriginal and Torres Strait Islander Health Practitioners consulting with patients in remote and rural settings.

Rationale 12

This recommendation focuses on increasing patient access to, and usage of, telehealth services. It is based on the following observations:

- The requirement for telehealth services to take place with specialists/consultations limits patient access to telehealth items. A survey of 73 Nurse practitioners (NPs) working in primary care and accessing MBS indicated that only 12% used telehealth items, and identified that the main reason for non-use of the telehealth items was the stipulation of having a specialist or consultant present (88).
- The addition of GPs as eligible telehealth providers will increase patient access to GPs, particularly in remote areas where GP access is more limited. The restriction to a patient's usual provider will ensure rural and remote practice sustainability. Rigorous consultation should be undertaken with rural and remote providers in the implementation of this recommendation.
- Expanding GP telehealth eligibility criteria to include patients with mobility concerns, such as patients who are elderly and frail, will increase patient access to essential services.
- The GPPCCC notes that the NPRG supports this recommendation.

GPPCCC Phase 2 Recommendation 12 – Referred

This recommendation was referred to the Telehealth Working Group.

4.2.4 General Practice and Primary Care Clinical Committee Stakeholder Impact Statement (Phase 2)

The GPPCCC expects that both patients and providers will benefit from these recommendations, as they address concerns regarding quality of care and take steps to simplify the MBS, making it easier to use and understand. Patient access to services was considered for each recommendation. Some recommendations were intended to reduce inappropriate access without significantly affecting appropriate access.

When considering various recommendations, the GPPCCC considered what impacts they may have on several specific groups, for example health assessments for patients with chronic disease/s.

Where items have been recommended for deletion, alternative items have been proposed or created when necessary. items that are obsolete have been recommended for deletion without replacement with the intent that any associated funding will be reinvested into primary care GP services.

The GPPCCC also considered each recommendation's impact on provider groups to ensure that the changes are reasonable and unbiased. Where the GPPCCC identified evidence of potential item misuse or safety concerns, recommendations were made to encourage best practice, in line with the overarching purpose of the MBS Review. Reductions in inappropriate use and low-value care are expected to deliver savings for the health system; with the expectation that reinvestment would occur along with a number of cost-neutral changes. The GPPCCC considered potential implications for provider groups and took steps to ensure that recommendations are as fair and reasonable as possible. Some business models may need to change or adapt to the proposed changes moving forward.

4.3 Aboriginal and Torres Strait Islander Health Reference Group

4.3.1 Aboriginal and Torres Strait Islander Health Reference Group's Areas of Responsibility

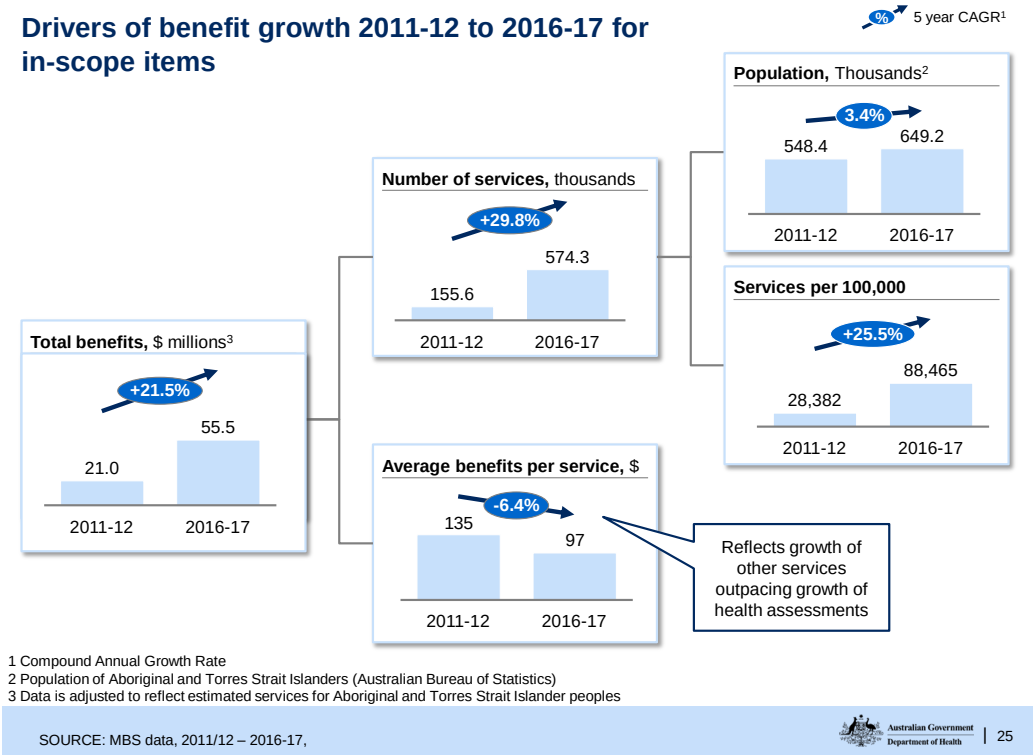
MBS items for Aboriginal and Torres Strait Islander peoples cover a diverse range of health services that are designed to ensure that Aboriginal and Torres Strait Islander peoples receive health care matched to their needs. In addition to reviewing specific MBS items, the Aboriginal and Torres Strait Islander Health Reference Group (the Reference Group) considered Aboriginal and Torres Strait Islander health across the MBS and issues referred by a number of clinical committees.

The Reference Group reviewed 21 MBS items from the following MBS groups:

- A14, health assessments, subgroup 2 – Aboriginal and Torres Strait Islander peoples' health assessments (item 715),
- M3, allied health services (item 10950),
- M11, allied health services for Aboriginal and Torres Strait Islander peoples who have had a health assessment (items 81300–81360), and
- M12, services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of another medical practitioner (items 10983–10997).

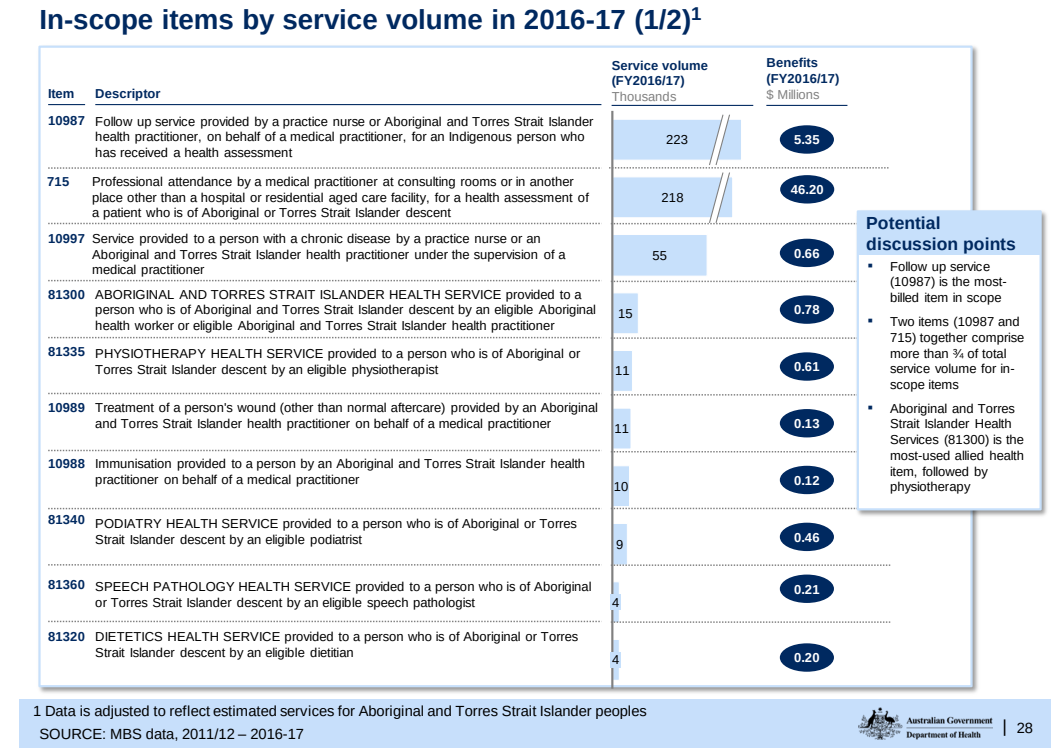
In the 2016-17, these items accounted for approximately 574,300 services and $55.5 million in benefits. Over the past five years, service volumes for Indigenous MBS items have grown by 29.8 per cent, with the cost of benefits decreasing by 6.4 per cent compounded annually (Figure 11).

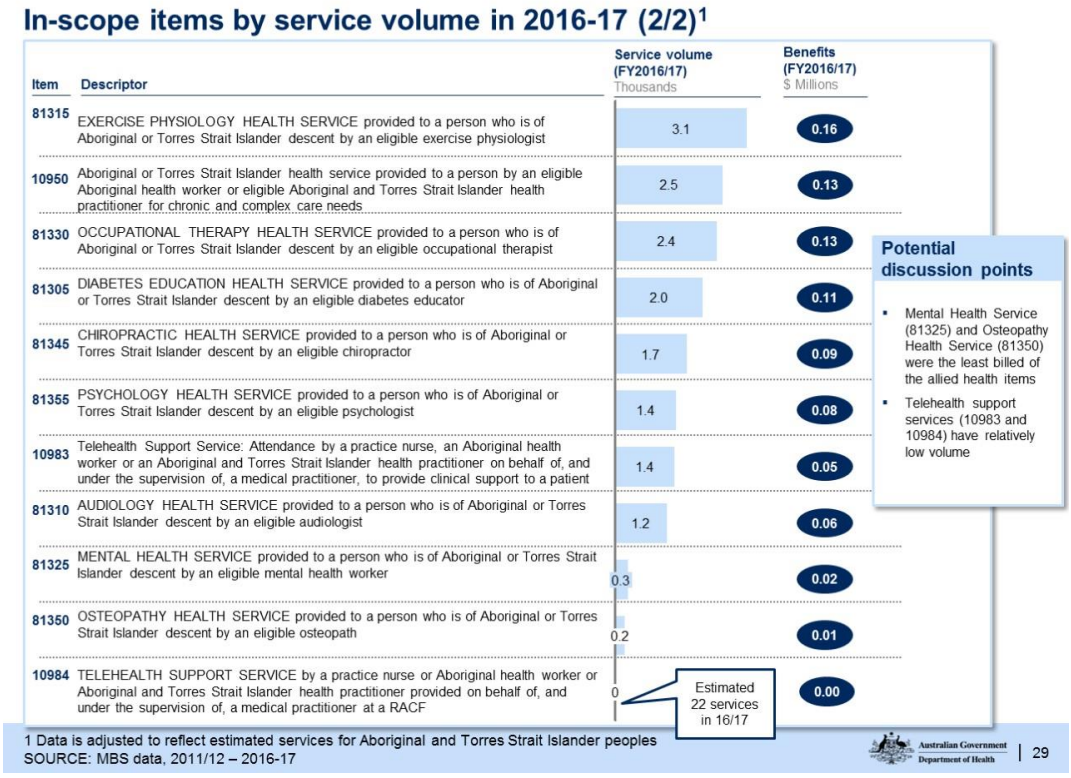
Figure 11: Aboriginal and Torres Strait Islander Health Reference Group – Drivers of benefit growth (2011-12 to 2016-17) for in-scope items



In 2016-17, follow-up services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner for Aboriginal and Torres Strait Islander peoples who had received a health assessment had the highest service volume (approximately 223,000 services). The Aboriginal and Torres Strait Islander health services item was the most utilised allied health item (Figure 12). In 2016-17, mental health services and osteopathy health services were the least billed allied health items (Figure 12).

Figure 12: Aboriginal and Torres Strait Islander Health Reference Group – In-Scope items by service volume (2016-17)





4.3.2 Aboriginal and Torres Strait Islander Health Reference Group's Review Approach

The Reference Group completed a review of its items across five meetings, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including data on:

a. utilisation of items (services, benefits, patients, providers and growth rates),

b. service provision (type of provider, geography of service provision); patients (demographics and services per patient),

c. co-claiming or episodes of services (same-day claiming and claiming with specific items over time), and

d. additional provider and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through medical journals and other sources, such as professional societies.

The Reference Group considered relevant stakeholder submissions to the MBS Review when making its recommendations.

Main themes

The Reference Group identified four main themes arising from its deliberations:

1. **Models of primary care financing and funding** - There were two recurring sub-themes revolving around managing patients' ability to cover out-of-pocket costs and the small health care workforce in some areas and communities.

2. **Prevention versus chronic disease management** – The importance of prevention in assessing potential health risks and conditions, with a view to picking up undiagnosed illness and identifying potential risks early in order to prevent disease later.

3. **MBS data on Aboriginal and Torres Strait Islander peoples** –The Medicare database provides an opportunity to examine MBS data concerning Aboriginal and Torres Strait Islander peoples, particularly as it is estimated that around 70 per cent of the Aboriginal and Torres Strait Islander population are recorded in the Medicare database.

4. **Updating and realigning MBS item descriptors** – The importance of bringing item descriptors in line with contemporary naming conventions.

Other issues

The Reference Group communicated and referred material to other committees and reference groups. It also examined the recommendations of other primary care clinical committees/reference groups. In this regard, the Reference Group supports the recommendation by the GPPCCC, the NPRG and the PMRG to develop telehealth solutions for GP-to-patient services.

The Reference Group also supports the recommendation by the MHRG to develop a new working group or committee to review access to MBS items for other mental health providers.

4.3.3 Aboriginal and Torres Strait Islander Health Reference Group Recommendations

Key recommendations

The Reference Group's recommendations are intended to address existing limitations and improve access to culturally safe, high-value, best-practice primary care. They focus on simplifying access to services, ensuring that existing services provide best-practice care and developing new services that reflect the needs of Aboriginal and Torres Strait Islander peoples.

The Reference Group's recommendations are summarised below.

Allied health services following an Aboriginal and Torres Strait Islander peoples' health assessment or GPMP with TCAs.

1. Enable bulk-billing incentives to be billed in conjunction with provision of allied health services for Aboriginal and Torres Strait Islander peoples.
2. Enable all allied health services available to Aboriginal and Torres Strait Islander peoples to be provided as group services.
3. Change the name of M11 and M3 items to "Comprehensive primary health care follow up services".
4. Pool access to allied health items that are available following the completion of a health assessment and the creation of a GPMP/TCA.
5. Increase the number of allied health sessions available for Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander peoples' health assessment follow-up services.

6. Create a new item for group service delivery of comprehensive follow-up services after a health assessment.

Aboriginal and Torres Strait Islander peoples' health assessments.

7. Ensure that health assessment templates and content (item 715) reflect best practice.
8. Update the allied health referral form for item 715.

Selected follow-up services following a GP management plan, health assessment and provision of immunisation or wound care provided on behalf of a medical practitioner.

9. Enable qualified Aboriginal and Torres Strait Islander health workers to claim for certain follow-up items provided on behalf of a medical practitioner that are currently allowed to be claimed by Aboriginal and Torres Strait Islander health practitioners (items 10987, 10988, 10989 and 10997).
10. Enable nurses to claim for certain immunisation and wound-care items provided on behalf of a medical practitioner, when provided in Aboriginal and Torres Strait Islander primary health care (10988 and 10989).

Longer-term recommendations

Broad recommendations that stretch beyond the scope of the MBS are listed below.

Service provision by Aboriginal and Torres Strait Islander health professionals without formal registration bodies.

11. Conduct research to enable MBS service provision by non-registered Aboriginal and Torres Strait Islander health professionals.
12. Invest in the growth and sustainability of the Aboriginal and Torres Strait Islander health worker and health practitioner workforce.
13. Invest in an awareness campaign that explains the roles and scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners.
14. Establish an MBS data governance, reliability and monitoring group to provide guidance and oversight of Aboriginal and Torres Strait Islander peoples' MBS claims data to ensure accuracy.
15. Ensure that all MBS revenue generated from the 19(2) Directions for state and territory clinics, funded under the Indigenous Australians' Health Programme, delivering primary health care to Aboriginal and Torres Strait Islander peoples is invested back into primary health care services.
16. Enhance social and emotional well-being support for Aboriginal and Torres Strait Islander peoples through an MBS rebate for social and emotional well-being support services delivered by accredited practitioners.
17. Promote culturally safe health services for Aboriginal and Torres Strait Islander peoples to all health providers.

Below are the recommendations from the Reference Group. These recommendations are intended to support existing services ensuring they are culturally safe, high-value and focus on encouraging best practice to improve patient care.

Where directly related to in-scope items, recommendations are organised into item groups. The order of the Reference Group's recommendations is not indicative of priority.

Note from the Taskforce:

The Taskforce is critically aware of the ongoing need for increased support and awareness to Aboriginal and Torres Strait Islander people and applied substantial consideration to all recommendations presented by the Aboriginal and Torres Strait Islander Health Reference Group.

The Taskforce supports a number of recommendations in principle, however, noted they are not appropriate in a fee for service setting such as the MBS; due to their required flexibility and a lack of evidence the MBS is not best placed to meet these needs.

Allied health services following an Aboriginal and Torres Strait Islander peoples' health assessment or GPMP

Increased use of allied health services (as a form of primary care) has the following benefits:

- Improved health outcomes and a reduction in the burden of chronic disease for Aboriginal and Torres Strait Islander peoples.
- Flow-on savings elsewhere in the health care system—for example, through reduced hospitalisation rates.

Recommendation 1 – Bulk-billing incentives for allied health appointments

The Reference Group recommends creating new items (mirroring items 10990, 10991 and 10992) for the provision of allied health services following a health assessment and/or the creation of a GPMP/TCA, with the following details:

a. the service is provided to an Aboriginal and Torres Strait Islander person,

b. the person is not an admitted patient of a hospital, and

c. the service is bulk-billed in respect of the fees for:

   (i) this item, and

   (ii) the other item in this table applying to the service.

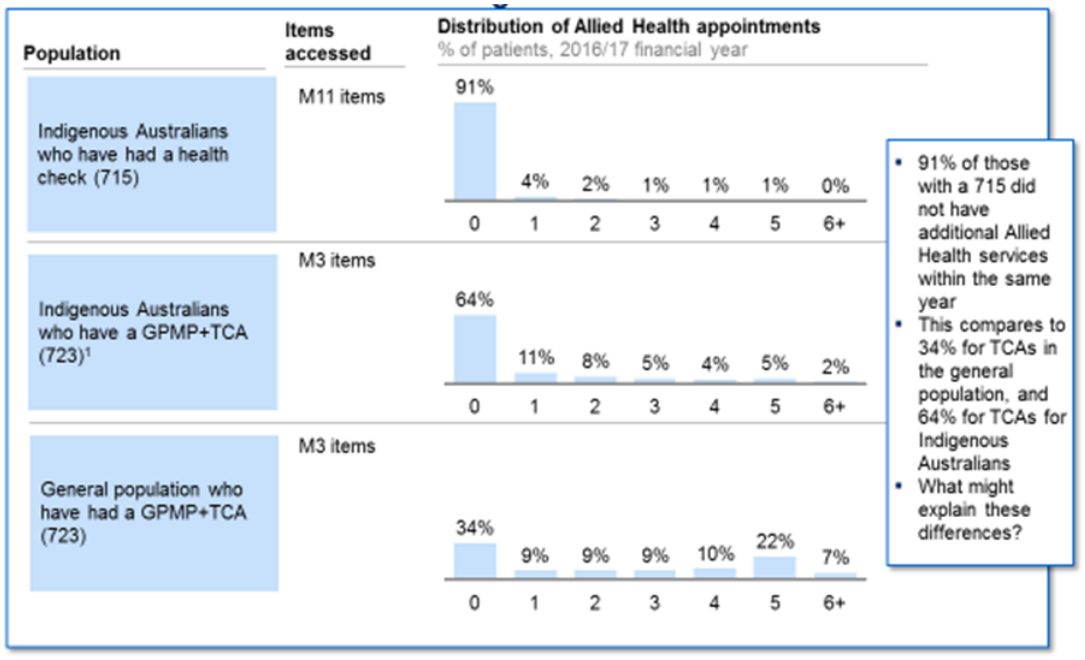
Rationale 1

This recommendation focuses on improving access to high value care. It is based on the following:

- Low numbers of Aboriginal and Torres Strait Islander peoples access rebates for MBS allied health appointments following a health assessment or GPMP/TCA, compared to uptake by all Australians.
- Despite some improvement in the number of Aboriginal and Torres Strait Islander peoples accessing health assessments and follow-up appointments over the last several years, uptake of these services remains low (30 per cent) compared to the size of the Aboriginal and Torres Strait Islander population (1).
- Less than 10 per cent of Aboriginal and Torres Strait Islander patients return for MBS follow-up services within 12 months of a health assessment (See Figure 13). It is also estimated that less than 40 per cent of Aboriginal and Torres Strait Islander patients return for follow-up services after a GPMP/TCA [6].
- In a study of 413 Aboriginal and Torres Strait Islander peoples who lived in urban areas and had received an adult health assessment, 62 per cent were referred on to follow-up appointments for allied health or specialist services. Referrals among this group were to dentists (178 people or 43 per cent), dietitians (86 people or 21 per cent), optometrists (51 people, or 12 per cent), audiologists (27 people or 7 per cent), mental health practitioners (20 people or 5 per cent) and specialists (excluding psychiatry 16 people or 4 per cent). Four per cent (15 people) received alcohol and drug referrals (2).

[6] Medicare statistics on the percentage of Aboriginal and Torres Strait Islander peoples who have had a GPMP/TCA are only estimates because not all patients have identified as Aboriginal and or Torres Strait Islander.

Figure 13: Aboriginal and Torres Strait Islander Health Reference Group – Average use of allied health appointments after referral from GPMPs and health assessments for Aboriginal and Torres Strait Islander peoples



- Out-of-pocket fees may be higher than current MBS data indicates. While official measures of bulk-billing rates for items 81300–81360 and 10950 are high (ranging between 26 per cent and 100 per cent for items 81300–81360, and 100 per cent for item 10950 (Figure 14 and Figure 15), the Reference Group agreed that these figures could be inaccurate. Based on clinical experience, some providers who bulk bill also charge out-of-pocket fees to patients. The Reference Group referred this issue to the compliance area of the MBS for investigation.
- Even if bulk-billing numbers are accurate, the disproportionately low levels of access to allied health services mean that the sample could still be biased towards bulk-billing providers (i.e. the services that are accessed could be more likely to be bulk billed, as patients simply do not access allied health services when these are not bulk billed).

Figure 14: Aboriginal and Torres Strait Islander Health Reference Group – Bulk-billing rates for M3 and M11 items (Part 1 of 2)

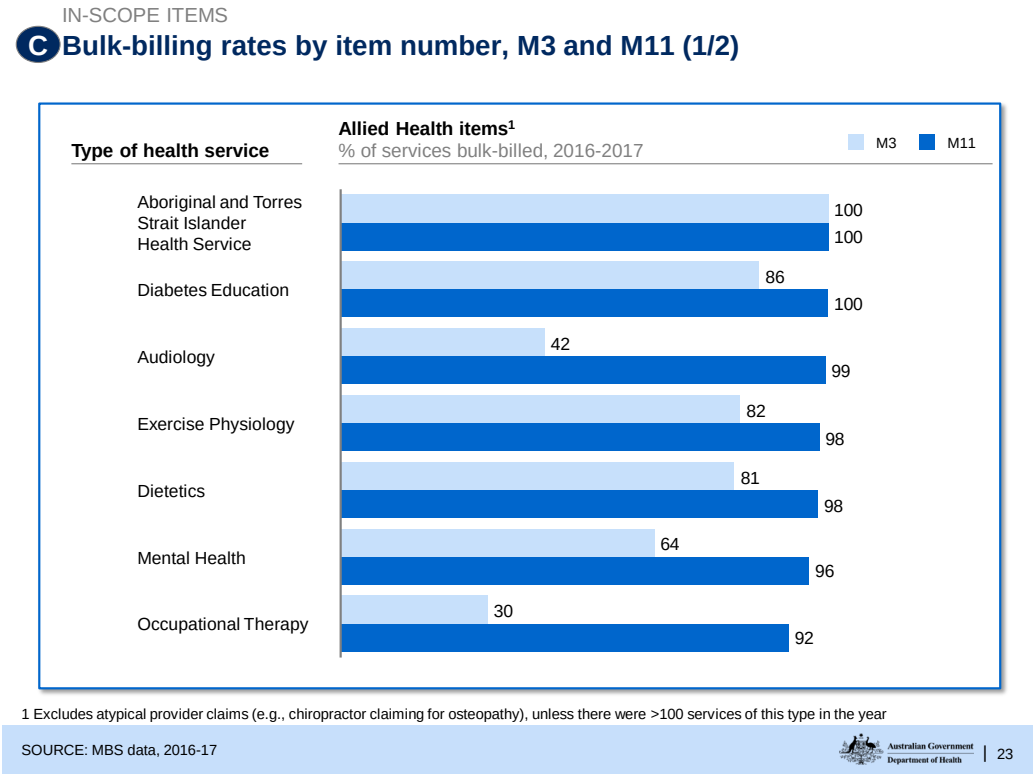
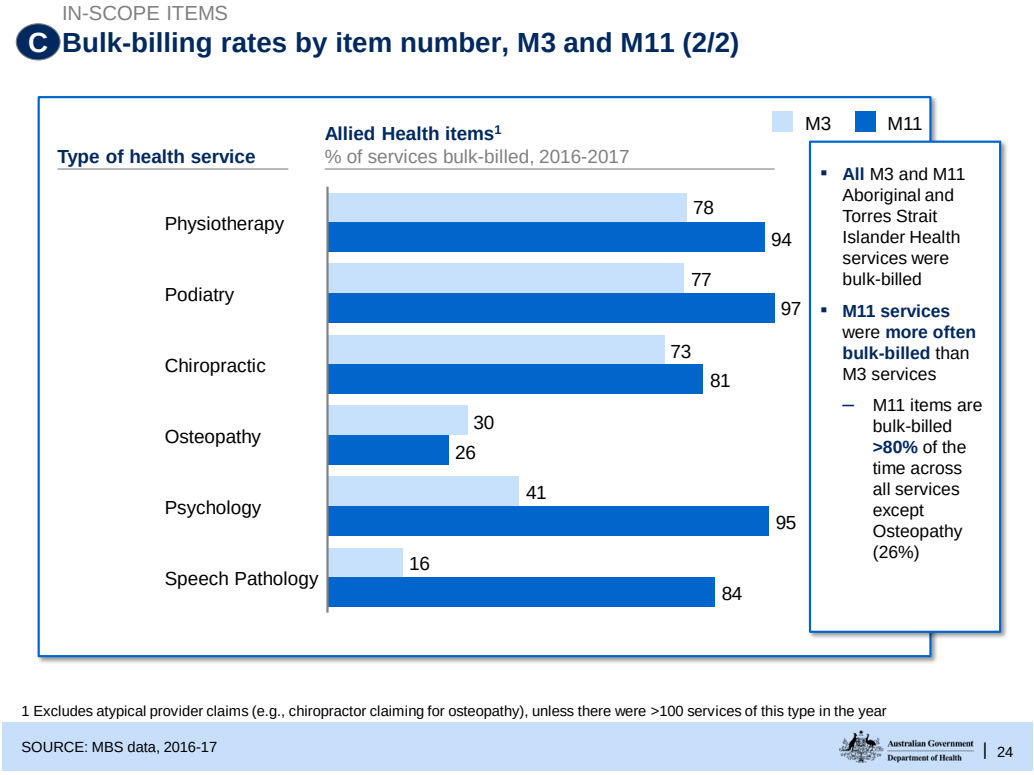


Figure 15: Aboriginal and Torres Strait Islander Health Reference Group – Bulk-billing rates for M3 and M11 items (Part 2 of 2)



- High out-of-pocket fees are limiting access to allied health care for Aboriginal and Torres Strait Islander peoples. The out-of-pocket cost of health care in Australia was found to be a barrier to people with

chronic health conditions and comorbidities accessing and receiving treatment. People with mental health conditions are particularly likely to skip care (3).

- Chronic diseases—such as CVD, cancer, diabetes and kidney disease—contribute to two-thirds of the health gap between Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples (4). In 2015, chronic conditions accounted for 77 per cent of the gap in mortality between Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples (including circulatory diseases, diabetes, cancer, kidney and respiratory diseases) (5).
- The average bulk-billing rate for allied health items for Aboriginal and Torres Strait Islander peoples who have had a health assessment (M11 items) is 89 per cent (Figure 14 and Figure 15). The average bulk-billing rate for allied health services for those who have a chronic care management plan (CCMP) (M3 items) is 62 per cent.
- Research has identified the removal of cost barriers as a potential avenue for improving follow-up care (6).
- Bulk-billing incentives are an effective tool to directly motivate providers to increase their rate of bulk billing and minimise the instances where out-of-pocket contributions from patients are required to gain access to a service.
- In aiming to reduce patients' out-of-pocket contributions, applying bulk-billing incentives may have a lower risk of perverse outcomes compared to increasing the schedule fee (where there is a risk that out-of-pocket fees may not decrease).
- The Reference Group agreed that creating new specific bulk-billing incentive items (that mirror 10990, 10991 and 10992) to enable them to be applied to allied health services for M11 items, and to item 10950 in M3, would be most appropriate.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 1 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports the clinical need to improve access for Aboriginal and Torres Strait Islander peoples to improve care, but does not believe that a bulk-billing solution is the best mechanism for TCAs and health assessments, and suggests a block payment may be more appropriate.

Recommendation 2 - Enable all allied health services available to Aboriginal and Torres Strait Islander peoples to be provided as group services

The Reference Group recommends creating new items (mirroring M11 items) for the provision of allied health services as group therapy, with the following details:

a. There should be two to 10 participants per group

b. items should be created for each eligible M11 provider

c. The new items should have a minimum duration of 20 minutes (specified in the item descriptor), with an expected duration of 60 minutes (specified in the explanatory notes), and

d. The sessions should be accessible through items 715 and 723 (refer to Recommendation 6).

Rationale 2

- This recommendation focuses on increasing the use of allied health services by providing options for group services. It is based on the following:
- Group services may offer increased cultural safety for Aboriginal and Torres Strait Islander patients. Gender-specific group sessions provide a culturally safe and familiar space for Aboriginal and Torres Strait Islander peoples to discuss their health and well-being. These sessions provide participants with a sense of unity and an understanding that they are not alone in the process. Participants may also feel more comfortable asking certain questions in a group environment.
- A 2016 study was conducted with Aboriginal and Torres Strait Islander men in Lismore, NSW, to explore the accessibility and appropriateness of shared medical appointments. This study suggested that these types of consultations offer a culturally safe way to engage Aboriginal and Torres Strait Islander men in primary care (7). The men stated that they enjoyed the "yarn up" nature of the group appointments and felt that they were not alone in the process. The men highlighted that they felt more comfortable in the more natural group setting, compared with one-on-one consultations.
- A 2014 study explored patient and provider satisfaction with shared medical appointments in NSW, SA, and Queensland (8). The study conducted 24 shared medical appointments with eight health care centres, one of which was an Aboriginal and Torres Strait Islander health centre. All participants in the Aboriginal and Torres Strait Islander peoples group were male. The men stated that the "yarning" aspect of a group session was a common cultural practice.
- These types of group yarning sessions are already being run, but patients cannot access rebates for these services under the MBS.
- No item currently exists for the provision of group allied health services for Aboriginal and Torres Strait Islander peoples who do not have diabetes. Group therapy for diabetes items can be accessed through a GPMP/TCA.
- Group therapy services offer a unique opportunity to more effectively deliver preventive care services to Aboriginal and Torres Strait Islander peoples (e.g. smoking cessation, diabetes educator group support, pre-diabetes groups). This reduces the burden of chronic disease and will also drive cost savings throughout the health system (9).
- Low rates of claiming allied health services among Aboriginal and Torres Strait Islander peoples may suggest the need for a complimentary mode of service delivery such as group therapy/services.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 2 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce acknowledges evidence on the value of group therapy and follow-up services, and supports improved access for patients, but agrees a fee for service model is not the best way to support delivery of these services due to variability in group definitions and types (e.g. the size of a group and the approach to the delivery of a service).

The Taskforce notes limitations in the fee-for-service model in promoting longitudinal care and addressing patient complexity and agrees further research should be undertaken on evidence-based models of successful non-MBS group therapy. Such evidence could inform consideration of non-fee for service solutions.

Recommendation 3 - Change the name of M11 and M3 items

The Reference Group recommends changing the name of M11 and M3 items (items 81300–81360 and 10950–10970) to "*Comprehensive primary health care follow up services*".

Rationale 3

- This recommendation focuses on ensuring that the MBS describes services appropriately. It is based on the following:
- Several providers who provide services under M11 and M3 items are not typically considered allied health professionals, including:
    - Aboriginal and Torres Strait Islander health workers,
    - Aboriginal and Torres Strait Islander health practitioners,
    - Mental health nurses, and
    - Nurses.
- Changing the name of group M11 and M3 items would more accurately reflect the group of providers and the scope of activities included in these services.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 3 – Not endorsed for Government consideration

The Taskforce notes this proposal would in effect change the definition of allied health professionals to include new provider groups. While the Taskforce acknowledges the rationale for this, additional research should be undertaken prior to such an expansion. This could be considered as part of the Primary Care Ten Year Plan and, following that, considered by following the appropriate MSAC process.

Recommendation 4 - Pool access to allied health items that are available following the completion of a health assessment and the creation of a GPMP/TCA

The Reference Group recommends:

a. pooling access to the allied health items that are available following an Aboriginal and Torres Strait Islander peoples' health assessment (item 715) and a TCA (item 723; generated through a GPMP for chronic disease management, under item 721), and

b. M11 items (allied health services for Aboriginal and Torres Strait Islander peoples who have had a health assessment) and M3 items (individual allied health services for chronic disease management) be accessible through both the health assessment pathway (item 715) and the TCA pathway (item 723).

Rationale 4

This recommendation focuses on decreasing administrative barriers to accessing allied health services for Aboriginal and Torres Strait Islander peoples. It is based on the following:

- Pooling M11 and M3 items would mean that patients can access rebates for a combined 10 services (instead of the five services currently available through each pathway), regardless of their entry pathway.

- The Reference Group recognises that this recommendation involves other M3 items beyond item 10950, which fall within the AHRG's area of responsibility.
- Patients referred to allied health services via a health assessment (item 715) or TCA (item 723) are currently able to access a total of five allied health services per year.
- Patients with chronic disease management plans under TCAs can access an additional five appointments each year by completing a health assessment (i.e. they can access up to 10 allied health services under Medicare per calendar year).
- M11 and M3 allied health items are delivered by the same providers at the same schedule fee. Having two means of accessing essentially the same services creates administrative barriers for consumers, promotes potentially unnecessary health assessments for chronic disease patients and adds complexity to the MBS. The Reference Group noted that this process also involves two referral forms, which could be reduced to a single form for Aboriginal and Torres Strait Islander peoples if the items were pooled.
- Use of MBS allied health sessions after a health assessment (item 715) and TCA (item 723) is low among Aboriginal and Torres Strait Islander peoples (Figure 13).
- Pooling the items available from both the health assessment (item 715) and TCA (item 723) pathways would:
    - Create a streamlined, more efficient and simpler experience for both patients and providers.
    - Remove the motivation for patients with TCAs (item 723) to undertake arbitrary health assessments to gain access to an additional five allied health services.
    - Enable patients who have had a health assessment (item 715) to claim five additional services, allowing for improved outcomes where access to more than five services in a year is beneficial to a patient's health.
- Current usage patterns of allied health services through both pathways suggest that the impact on total service volumes is likely to be low.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 4 – Endorsed for Government consideration

The Taskforce supports this recommendation and the Reference Group's rationale, noting this should be carefully reviewed to ensure there are no unintended consequences on the value of assessment in the interests of the patient.

Recommendation 5 - Increase the number of allied health sessions available for Aboriginal and Torres Strait Islander peoples

The Reference Group recommends increasing the number of available allied health sessions following a health assessment (item 715).

Rationale 5

This recommendation focuses on providing high-value care through increased access to allied health services for Aboriginal and Torres Strait Islander peoples. It is based on the following:

- Patients who have been referred to allied health services via a health assessment (item 715) are currently able to access a total of five allied health sessions per year. This is often insufficient to provide high-quality care, especially when providing care for Aboriginal and Torres Strait Islander peoples.

- The Australian Physiotherapy Association, in the case of stress incontinence would recommend a program of six physiotherapy sessions. Similarly, for those at risk of developing persistent pain, a program of up 10 sessions to be used over a calendar year. However, for the complex patient, an Aboriginal male, aged 50, obese, smoker, diabetic, cardiovascular disease risk, with previous injuries manifested in arthritis with chronic low back pain and low level depression would require more than 10 sessions with a physiotherapist alone in a calendar year. This Aboriginal Male may also require funded visits to an Aboriginal and Torres Strait Islander health worker for smoking cessation, a dietician, psychologist, podiatrist and/or diabetes nurse.
- Although few Aboriginal and Torres Strait Islander peoples reach the cap of five sessions under item 715 (Figure 13), demand for these sessions is expected to increase. Other recommendations by this Reference Group (e.g. refer to Recommendations 2, 4 and 8) are likely to increase the use of M11 health services. This may increase the number of Aboriginal and Torres Strait Islander peoples reaching the cap of five sessions per year.
- The Minister for Indigenous Health, the Hon. Ken Wyatt MP, has identified a need to increase the use of item 715. This may result in an increase in allied health use.
- Other under-served populations have recognised the need for greater access to allied health appointments. Upon reviewing the available allied health services, the DVA recommended a new "treatment cycle" model of service delivery to improve the quality of allied health care arrangements. In this model, GPs would refer patients to allied health services for up to 12 sessions per year (10).
- Five sessions are currently available per year. While the Reference Group did not align on a final number, it discussed an increase to 15 available sessions, with each additional five sessions available after review by the patient's GP.
- This recommendation would mean that each patient who had undergone a health assessment (item 715) or had a TCA (item 723) would receive access to 10 allied health sessions annually, with an additional 10 sessions available pending GP review.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 5 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports this recommendation in principle, and accepts the number of allied health sessions should be increased to improve access, but agrees alternative models and pathways outside the MBS should be explored and considered instead.

The Taskforce notes that there are limitations in the fee for service model given variance possibilities (e.g. workforce, viability of service delivery, urban versus rural, how to appropriately support), and that this is a broader issue than the MBS.

Aboriginal and Torres Strait Islander peoples' health assessment follow-up services

Recommendation 6 - Create a new item for group service delivery of comprehensive follow-up services after a health assessment

The Reference Group recommends adding a new item that allows for group service delivery of follow-up services after a health assessment (item 715) by a nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker, with the proposed item descriptor as follows:

New item – example descriptor

Follow up service provided by a nurse, Aboriginal and Torres Strait Islander health practitioner, or Aboriginal and Torres Strait Islander health worker, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment if:

a) the service is provided on behalf of and under the supervision of a medical practitioner, and

b) the person is not an admitted patient of a hospital, and

c) the service is consistent with the needs identified through the health assessment or associated consultation after the health assessment - to a maximum of 10 services per patient in a calendar year

Group service with a group of 2-10 participants

The service must have a minimum duration of 20 minutes

Rationale 6

- This recommendation focuses on increasing the availability and use of group services. It is based on the following:
- Group services may offer increased cultural safety for Aboriginal and Torres Strait Islander patients (see the Rationale 2).
- Group service delivery of follow-up services after an Aboriginal and Torres Strait Islander peoples' health assessment may increase the likelihood of Aboriginal and Torres Strait Islander patients attending follow-up services, promoting continuity of care.
- Group services offer more cost-effective options for providing follow-up services after health assessments. Group consultations provide a complimentary form of effective chronic disease management. This type of care can lead to better health outcomes, an increase in patient and provider satisfaction, lower costs and more timely access to care. It has been suggested that group consultation could hold promise for groups with low levels of health literacy, including Aboriginal and Torres Strait Islander peoples (11).
- Shared medical appointments can reduce the cost of managing some group-based approaches (such as diabetes groups) by 20 to 30 per cent. There is a high degree of patient and practitioner satisfaction with shared medical appointments and group consultations in chronic care management in Australia. People also feel that they are able to gain more education and information about their own conditions through this form of care.
- Group therapy services offer a unique opportunity to deliver preventive care.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 6 – Not endorsed for Government consideration

The Taskforce acknowledges evidence on the value of group therapy and follow-up services and acknowledges that there may be an increased place to support group therapy in the context of care for Aboriginal peoples and Torres Strait Islanders. However, there are inherent limitations in the MBS, both in terms of variability in group definitions and types (i.e. the size of the group and the approach to the

delivery of a service) and the extent to which a fee-for-service model could genuinely address these needs.

The Taskforce instead recommends that work is undertaken to investigate alternative and more flexible models of service delivery, including research on evidence-based models of successful group therapy which meets both the clinical and cultural needs of this population. Such evidence could inform consideration of non-MBS solutions that better meet these identified needs.

Aboriginal and Torres Strait Islander peoples' health assessments

Recommendation 7 - Ensure that health assessment templates and content reflect best practice

The Reference Group recommends:

a. regularly updating the *National Guide to a Preventive health assessment for Aboriginal and Torres Strait Islander People* to ensure that it aligns with current practice and evidence and becomes a "living guideline", to the extent possible, including:

   (i) Incorporating validated instruments such as Audit-C for alcohol and the absolute cardiovascular risk calculation into the guide. Specifying the inclusion of a sexual health check in the guide (where it is age appropriate).

b. translating the national guide into easy-to-use templates for clinicians, including exploring opportunities to adapt clinical software systems to improve Aboriginal and Torres Strait Islander peoples identification rates and reconsideration of the currently defined age groups (including the possibility of a "young persons' check"),

c. updating DoH's templates for item 715 to align with the national guide,

d. once the revised templates have been finalised, amending the item descriptor for item 715 to require an Aboriginal and Torres Strait Islander peoples' health assessment to be completed using a template issued by DoH, or a template that contains all the components of the form issued by DoH, with the proposed item descriptor as follows:

Item 715 – example item descriptor

Professional attendance by a GP at consulting rooms or in another place other than a hospital, to perform a health assessment for an Aboriginal and/or Torres Strait Islander patient, not more than once in a 9-month period. The health assessment must include:

a) recognition of patient health priorities, and

b) collection of relevant information, including a comprehensive patient history, and

c) relevant physical examination, and

d) initiating interventions, investigations and referrals, and

e) providing comprehensive preventive health care advice and other measures informed by overall assessment and patient priorities, and

f) developing a plan for follow-up as based on overall assessment and patient priorities

as per current Australian preventive health guidelines, that are culturally and clinically suitable to Aboriginal and Torres Strait Islander needs, are evidence-based and are generally accepted in primary

care practice, completed using a template issued by the Department, or a template that contains all the components of the form issued by the Department.

and

e. replacing the existing associated notes (AN.0.43, AN.0.44, AN.0.45, AN.0.46) with the amended associated note with the proposed text as follows:

Associated Note item 715 – example descriptor

This MBS 715 health assessment is available to all Aboriginal and Torres Strait Islander people and should be used for health assessments in the following age categories:

- infants and young children
- primary school age
- adolescents and young adults
- adults
- older people

A health assessment means the assessment of physical, psychological, social, emotional and cultural factors and consideration of what preventive health care and other measures will support the patient's health and wellbeing.

The intention of the health assessment is to:

a) support initial and ongoing engagement in comprehensive primary healthcare in a culturally safe way,

b) provide evidence-based age-appropriate health information and services to support health and wellbeing for primary and secondary disease prevention,

c) identify and support management of health and health-related needs, and

d) support established population health programs (e.g. immunisation, cancer screening) and other high quality primary health care (e.g. oral health & dental care)

The elements of the health assessment should include age-appropriate:

- patient priorities,
- developmental, biomedical and chronic disease risk/healthy lifestyle factors,
- assessment of social and emotional wellbeing (SEWB), and
- as per current Australian preventive health guidelines, that are culturally and clinically suitable to Aboriginal and Torres Strait Islander needs, are evidence-based and are generally accepted in primary care practice, such as the NACCHO-RACGP *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people* and the Central Australian Rural Practitioner's Association (CARPA) *Standard Treatment Manual*.

A high quality MBS 715 health assessment is:

- a positive experience for the patient, whereby patient priorities and experience in the consultation have primacy,
- culturally affirming and has cultural elements including Aboriginal/Torres Strait Islander people involved in provision of care whenever possible,
- provided with a patient, not to a patient,
- provided by the usual general practice or Aboriginal Health Service whenever possible. For the purpose of the health assessment, "usual general practice or Aboriginal Health Service" means those who have provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months
- where it is not possible for the “usual general practice or Aboriginal Health Service” to conduct the health assessment, and it is undertaken by a GP in another general practice or Aboriginal Health Service, this practice must obtain the details of the patient’s “usual general practice or Aboriginal Health Service”, and they must forward a copy of the summary of the outcomes of the health assessment (with the permission of the patient/parent/guardian or carer), to ensure continuity of care to the patient and follow up care if required.
- GP-led, often as a team-based service with multiple contributors (e.g. Aboriginal and Torres Strait Islander Health practitioners/workers, nurses) in different episodes of care over time,
- relationship-strengthening and supports patient agency, and
- evidence-based as per current Australian preventive health guidelines that are culturally and clinically suitable to Aboriginal and Torres Strait Islander needs generally accepted in primary care practice

A clear plan of action should be developed with the patient to support patient goals and follow-up of identified health needs. This should be documented in the patient record, available to the patient and a copy shared as appropriate and with patient agreement.

Health assessments for children should be completed with input from adults who have responsibility for their care (parent, family member, carer) to:

a) provide consent for the health assessment,

b) share the child’s relevant health history and living circumstances, and

c) share knowledge and responsibility for health needs identified and planned follow-up.

Completion of the MBS 715 health assessment is expected to take 30-60 minutes with a minimum of 15 minutes provided by a GP. Suitably qualified health professionals, such as nurses, Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners, may complete parts of the health assessment that are within their professional scope of practice. Final responsibility for a health assessment that meets the requirements for MBS reimbursement remains with the GP.

Note: The Reference Group is aware that the RACGP and the National Aboriginal Community Controlled Health Organisation (NACCHO) have developed resources for implementing the National Guide to a preventive health assessment for Aboriginal and Torres Strait Islander peoples (item 715) and tools to support clinicians utilising the item, and increase uptake of the item.

Rationale 7

This recommendation focuses on improving the quality of health assessments to reflect best practice and optimise patient outcomes. It is based on the following:

- The annual volume of health assessment services (item 715) is increasing, from less than 100,000 a year in 2011-12 to over 230,000 by 2017-18 (MBS Statistics).
- In 2016-17, 29 per cent of Aboriginal and Torres Strait Islander peoples received a health assessment. The Australian Government has set a target of increasing this to 65 per cent by 2023 (12).
- The Reference Group agreed that some elements of the current health assessment do not reflect best practice. There is no requirement, or guidance, to ensure that the activities outlined in the *National Guide to a Preventive health assessment for Aboriginal and Torres Strait Islander People* are performed during a health assessment (item 715).
- Some mandatory elements of the health assessment, as well as the standard templates, do not represent best-practice care, e.g.:
    - There is no requirement for an absolute CVD risk assessment. CVD is the largest contributor to the health gap between Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples and is responsible for 21 per cent of the fatal disease burden among Aboriginal and Torres Strait Islander peoples (13). More than 55 per cent of Aboriginal and Torres Strait Islander peoples between the ages of 35 and 74 who are at high risk of CVD are not receiving lipid-lowering therapy. The current health assessment under item 715 adopts a single-risk-factor approach, which is known to miss people at high risk and underestimate risk more broadly (20). Most guidelines recommend an absolute risk approach to CVD. Experts in Aboriginal and Torres Strait Islander peoples' CVD prevention and Aboriginal and Torres Strait Islander leaders supported this approach at a recent roundtable (14).
    - Some assessments have been identified as culturally inappropriate, or of minimal value, due to limited capacity for referral or follow-up.
    - There is often no facilitation of shared decision-making and limited patient-centred focus in the design of the health assessment templates (12).
- The Reference Group agreed that enshrining a template that reflects current clinical guidelines within the item descriptor would ensure that item 715 remains up to date and reflects best practice. The current MBS template is widely used and referenced, which means that changes to item 715 can have a widespread effect on practice.
- The RACGP and NACCHO are developing resources to implement the National Guide to a preventive health assessment for Aboriginal and Torres Strait Islander people (item 715) and tools to support clinicians utilising the item and increase uptake of the item. As such, they are well placed to recommend improvements.
- The Reference Group also discussed reconsidering the currently defined age groups for health assessments to create an age tier for younger patients however did not reach a decision on this.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 7 – Endorsed for Government consideration

The Taskforce supports this recommendation and the Reference Group's rationale.

Recommendation 8 - Update the allied health referral form for Aboriginal and Torres Strait Islander peoples' health assessment

The Reference Group recommends:

a. changing the Referral Form for Follow-Up Allied Health Services Under Medicare for People of Aboriginal or Torres Strait Islander Descent by adding "(optional)" at the end of the section that states: "Allied Health Professional (AHP) patient referred to: (Specify name or type of AHP)",

b. ensuring that the allied health professions listed on this form are consistent with the Referral Form for Individual Allied Health Service under Medicare for Patients with a Chronic Medical Condition and Complex Care Needs,

c. supporting electronic completion of this form where possible and changing the explanatory note to reflect this, and

d. removing the requirement for written referrals and reporting by allied health professionals to be done outside of the patient clinical record where there is a shared electronic health record used by the referring GP and allied health professional. Note: If both health professionals enter in the same medical notes, as a consumer the organisation should have a clear process, when the AHP has completed their first and last consultation with the patient the GP is alerted and reviews the notes and takes necessary action. The information may be in the medical notes though there isn't a guarantee they are reviewed. If there isn't a clear process identified by the AHP and GP continuity of care may not occur, and the patient may only return with they need critical care again. This needs to be included in the criteria.

Rationale 8

This recommendation focuses on ensuring clear communication between the patient and the GP and facilitating access to allied health services. It is based on the following:

- The current form does not make it clear that specifying the name and type of allied health professional is optional. Reference Group members noted that practitioners sometimes fill in this section of the form because they believe they are required to, which inadvertently limits a patient's choice to see a different allied health professional. While patients are not obligated to visit the allied health professional nominated on the referral form, most patients are not aware of this. The Reference Group agreed that clarifying that this section of the form is optional would resolve this issue.
- The allied health professional providing the service may be a member of the TCAs team convened by the GP or other medical practitioner to manage a patient's chronic condition and complex care needs. However, the service may also be provided by an allied health professional who is not a member of the TCAs team, provided that the service has been identified as necessary by the patient's GP or other medical practitioner and recommended in the patient's care plan/s.
- The Reference Group noted that electronic forms are easier to track than paper-based ones. The Reference Group noted that paper copies of referral forms being misplaced could be a contributor to the low use of allied health assessments.
- The Reference Group noted the availability of free online training videos on sending allied health professionals referrals electronically, e.g. Train IT Medical videos) (8).
- The Reference Group noted that, where there is a shared electronic health record used by the referring GP and allied health professional, the requirement for a separate referral form and reporting outside of the clinical record may constitute an additional administrative barrier without any additional benefit to continuity of care, clinical governance of patient safety. When entering into the same medical notes, an internal process needs to be adopted to ensure continuity of care for the patient.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 8 – Endorsed for Government consideration

The Taskforce supports this recommendation and the Reference Group's rationale.

The Taskforce notes the MBS may not be the appropriate mechanism to provide flexible culturally sensitive health care services and recommends ongoing research on how the needs of Aboriginal and Torres Strait Islander peoples can best be met through MBS and non-MBS means.

Services provided on behalf of a medical practitioner

Recommendation 9 - Enable qualified Aboriginal and Torres Strait Islander health workers to claim for certain follow-up items

The Reference Group recommends:

a. enabling qualified Aboriginal and Torres Strait Islander health workers to claim all items that Aboriginal and Torres Strait Islander health practitioners can currently claim (items 10987, 10988, 10989 and 10997), where these services fall within their scope of practice (as defined by the relevant state or territory), and

b. amending the descriptors for items 10987, 10988, 10989 and 10997 to reflect the option of service provision by a qualified Aboriginal and Torres Strait Islander health worker, as follows:

item 10987 – example descriptor

Follow up service provided by a nurse, Aboriginal and Torres Strait Islander health practitioner, or a qualified Aboriginal and Torres Strait Islander health worker on behalf of a medical practitioner, for an Indigenous person who has received a health assessment if:

a) the service is provided on behalf of and under the supervision of a medical practitioner, and

the person is not an admitted patient of a hospital, and

the service is consistent with the needs identified through the health assessment or associated consultations after the health assessment

to a maximum of 10 services per patient in a calendar year

item 10988 – example descriptor

Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner or a qualified Aboriginal and Torres Strait Islander health worker working within their scope of practice if:

a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner, and

b) the person is not an admitted patient of a hospital.

item 10989 – example descriptor

Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner or a qualified Aboriginal and Torres Strait Islander health worker working within their scope of practice if:

a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner, and

b) the person is not an admitted patient of a hospital.

item 10997 – example descriptor

Service provided to a person with a chronic disease by a nurse, an Aboriginal and Torres Strait Islander health practitioner, or a qualified Aboriginal and Torres Strait Islander health worker if:

a) the service is provided on behalf of and under the supervision of a medical practitioner, and

the person is not an admitted patient of a hospital, and

the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place, and

the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan

to a maximum of 5 services per patient in a calendar year

Rationale 9

This recommendation focuses on improving the availability of services for Aboriginal and Torres Strait Islander peoples. It is based on the following:

- Aboriginal and Torres Strait Islander health workers and health practitioners play an important role in providing high-quality health care to Aboriginal and Torres Strait Islander peoples. In a recent series of focus groups, Aboriginal and Torres Strait Islander peoples stated a preference for culturally sensitive, in-person support and information provided through face-to-face discussions (15). Aboriginal and Torres Strait Islander health workers were also recognised as important in providing cultural safety and support and helping to alleviate concerns (15). Face-to-face discussions are the preferred source of information for Aboriginal and Torres Strait Islander peoples (15).
- While there is an insufficient supply of Aboriginal and Torres Strait Islander health workers and health practitioners, there are more Aboriginal and Torres Strait Islander health workers than Aboriginal and Torres Strait Islander health practitioners. Adding Aboriginal and Torres Strait Islander health workers, that have the skills, knowledge and ability to provide services "for and on behalf of GPs" would triple the number of available Aboriginal and Torres Strait Islander health professionals and bring Australia closer to closing the gap. There are only 641 registered Aboriginal and Torres Strait Islander health practitioners (16) and 1,256 Aboriginal and Torres Strait Islander health workers in Australia (2011 figures) (5).
- Medication administration is a core unit in the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care Practice and the Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care Practice. However, all states and territories have their own legislation regarding handling, possessing and administrating medications for Aboriginal and Torres Strait Islander health workers and health practitioners (17).

- In NSW, for example, Aboriginal and Torres Strait Islander health workers and health practitioners are not permitted to possess, supply or administer medicines or vaccines. Those with the Aboriginal and Torres Strait Islander primary care qualification are able to provide information about commonly used medicines and immunisation services, assess a client's medicine history, provide information about immunisation and support clients in the safe and appropriate use of medicines (17).
- Increasing patients' ability to claim rebates for basic medical services will support the growth of the Aboriginal and Torres Strait Islander health workforce, which has been limited over the previous two decades. In 1996, there were 19 Aboriginal and Torres Strait Islander health workers per 10,000 Australians. By 2011, this had only increased to 23 per 10,000 Australians (5).
- Increasing patients' access to services from Aboriginal and Torres Strait Islander health workers will improve the quality of care in rural and remote areas.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 9 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce acknowledges the importance of Aboriginal and Torres Strait Islander Health Workers within the primary health workforce. However, given the expansionary nature of this recommendation, the Taskforce agrees that this recommendation should follow the appropriate MSAC process rather than be endorsed through the MBS Review process.

Further, the Taskforce agrees the MBS may not be the appropriate mechanism to provide flexible culturally sensitive health care services, and recommends ongoing research on how the needs of Aboriginal and Torres Strait Islander peoples can best be met through MBS and non-MBS means.

Recommendation 10 - Enable nurses to claim for certain immunisation and wound-care items provided on behalf of a medical practitioner, when provided in Aboriginal and Torres Strait Islander primary health care

The Reference Group recommends:

a. enabling nurses working in Aboriginal and Torres Strait Islander primary health care services to be added to the list of eligible health practitioners providing immunisation and wound care services under items 10988 and 10989,

b. amending the item descriptors as follows:

Item 10988 – example descriptor

Immunisation provided to a person by a nurse working in an Aboriginal primary care health service, an Aboriginal and Torres Strait Islander health practitioner, or an Aboriginal and Torres Strait Islander health worker working within their scope of practice if:

a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner, and

b) the person is not an admitted patient of a hospital.

Item 10989 – example descriptor

Treatment of a person's wound (other than normal aftercare) provided by a nurse working in an Aboriginal primary care health service, an Aboriginal and Torres Strait Islander health practitioner, or an Aboriginal and Torres Strait Islander health worker working within their scope of practice if:

a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner, and

b) the person is not an admitted patient of a hospital.

and

c. changing the term "practice nurse" to "nurse" across the MBS to be in line with current professional nomenclature.

Note: The Reference Group notes the interaction between Recommendations 9 and 10. The proposed item descriptors reflect both recommendations.

Rationale 10

- This recommendation focuses on improving the availability of services for Aboriginal and Torres Strait Islander patients. It is based on the following:
- The Reference Group agreed that while it is common practice for nurses to provide the services specified in items 10988 and 10989, there is no MBS item to rebate the patient for these services.
- The Reference Group agreed that in the interest of improved quality care, expanding access for nurses to items 10988 and 10989 is preferable because it removes the need to involve the GP in cases where he or she is not required and it more accurately reflects who is providing the service.
- Nurses are adequately trained to provide immunisation and wound care services, as described in items 10988 and 10989.
- The Reference Group agreed that expanded access to these items should only apply to Aboriginal and Torres Strait Islander primary health care services to adequately target it to Aboriginal and Torres Strait Islander peoples.
- The Reference Group notes that the GPPCCC supports the recommendation to replace "practice nurse" with "nurse" across the MBS.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 10 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports this recommendation in principle, but agrees the proposal presented is outside the remit of the MBS Review.

The Taskforce also notes there are already incentive programs in place outside of the MBS, such as the Practice Nurse Incentive Program (PNIP) payment and the Workforce Incentive Payment, to address this need. However, the Taskforce agrees the current incentive payment is not effective and suggests this is explored through an alternative pathway – one option could be to reduce the PNIP and roll it into a new item.

The Taskforce also suggests that credentialing/scope of practice considerations should be considered in any further discussions around this recommendation.

Longer-term recommendations

Service provision by Aboriginal and Torres Strait Islander health professionals without formal registration bodies

Recommendation 11 - Investigate the best way to integrate Aboriginal and Torres Strait Islander health professionals who do not have formal registration bodies into the MBS

The Reference Group recommends that:

a. the Government investigate the best way to integrate Aboriginal and Torres Strait Islander health professionals who do not have formal registration bodies into the MBS, and

b. this list could include Ngangkari healers and other Aboriginal and Torres Strait Islander health professionals who do not have formal registration bodies.

Rationale 11

This recommendation focuses on ensuring that other forms of spiritual and emotional care are considered as integral to health and wellbeing. It is based on the following:

- The Reference Group agreed that there is a shortage of effective, culturally safe primary health services for Aboriginal and Torres Strait Islander peoples.
- Precedent exists of other non-registered Aboriginal health professionals able to claim under the MBS (items available for Aboriginal and Torres Strait Islander health workers).
- There are many Aboriginal and Torres Strait Islander health professionals who could provide services specified in MBS items, despite not meeting the required registration standards. These health professionals are essential to ensuring social and emotional well-being and culturally safe care for Aboriginal and Torres Strait Islander peoples.
- Establishing a pathway for these providers to offer MBS rebated services would require additional research before implementation.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 11 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports this recommendation in principle, but agrees the proposal presented is outside the remit of the MBS Review.

The Taskforce notes that the issue of other practitioner access to appropriate funding is a wider issue than just the MBS, and should be considered across the entire healthcare system.

The Aboriginal and Torres Strait Islander health worker and health practitioner workforce

Recommendation 12 - Invest in the growth and sustainability of the Aboriginal and Torres Strait Islander health worker and health practitioner workforce

The Reference Group recommends the following:

a. increasing access to education pathways to become an Aboriginal and Torres Strait Islander health worker or health practitioner, by:

   (i) Increasing financial support for Aboriginal and Torres Strait Islander peoples who want to become an Aboriginal and Torres Strait Islander health worker or health practitioner.

   (ii) Ensuring that education programs for Aboriginal and Torres Strait Islander health workers and health practitioners are accessible to Aboriginal and Torres Strait Islander peoples, including ensuring that they are conveniently located and supported through online platforms.

b. facilitating the transition to work, by:

   (i) Providing financial incentives to practices for hiring Aboriginal and Torres Strait Islander health workers and health practitioners.

   (ii) Developing a target Aboriginal, Torres Strait Islander health worker, and health practitioner workforce to population ratio against which to track progress.

   and

c. strengthening the career path for Aboriginal and Torres Strait Islander health workers and health practitioners by:

   (i) Concentrating on reducing training and development challenges faced by primary health care organisations in hiring Aboriginal and Torres Strait Islander health workers and health practitioners.

   (ii) Ensuring access to education programs that facilitate the transition from Aboriginal and Torres Strait Islander health worker to health practitioner and from Aboriginal and Torres Strait Islander health practitioner to other health professions.

   (iii) Considering innovative approaches, such as micro-credentialing programs, delivered in community, that can provide entry pathways and are focused on preventative primary health care.

Rationale 12

This recommendation focuses on ensuring that Aboriginal and Torres Strait Islander peoples have access to qualified health professionals, in both urban and remote areas. It is based on the following:

- There is a shortage of qualified health professionals who can provide culturally and clinically appropriate care to Aboriginal and Torres Strait Islander peoples (5). This is partly because Aboriginal and Torres Strait Islander peoples are significantly under-represented in the Australian health workforce (5).
- Aboriginal and Torres Strait Islander peoples living in rural and remote communities suffer poor outcomes partly because of their educational disadvantage and their remoteness (18).
- Aboriginal and Torres Strait Islander health workers and health practitioners play an important role in providing culturally safe, comprehensive primary health services to Aboriginal and Torres Strait Islander peoples. They are also well distributed in rural and remote regions in Australia. Of the 987 full-time equivalent (FTE) Aboriginal and Torres Strait Islander health workers and health practitioners, 29 per cent (282 FTE) were in outer regional areas and 27 per cent (268 FTE) were in very remote areas (19).
- On 1 August 2018, at Council of Australian Governments Health Council, ministers agreed to develop a National Aboriginal and Torres Strait Islander Health Workforce Plan (20). These recommendations are of particular relevance in the context of that reform process.

- The Reference Group agreed that supporting the growth of the Aboriginal and Torres Strait Islander health worker and health practitioner workforce would be an efficient way to increase access to culturally and clinically appropriate care for Aboriginal and Torres Strait Islander peoples at high risk of poor health outcomes. It would also be a major employment opportunity for Aboriginal and Torres Strait Islander peoples as there are many unfilled positions for Aboriginal and Torres Strait Islander health practitioners with nurses currently meeting the demand for these services.
- The Reference Group agreed that the recruitment and training of Aboriginal and Torres Strait Islander health workers and health practitioners needs to be improved across Australia by:
    - Providing access to training to enable additional workforce capacity.
    - Developing a clear training pathway to demonstrate options for progression within the health workforce.
    - Developing an approach to ensure clear and consistent recognition of prior learning.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 12 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports this recommendation in principle, but agrees the proposal presented is outside the remit of the MBS Review.

Recommendation 13 - Invest in an awareness campaign that explains the roles and scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners

The Reference Group recommends investing in an awareness campaign that explains the roles and scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners to:

a. Target primary health care bodies operating in areas with substantial concentrations of Aboriginal and Torres Strait Islander peoples.

b. Involve peak bodies in the Aboriginal and Torres Strait Islander workforce, such as the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA).

c. Use online resources to define the scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners.

d. Articulate the health benefits of involving Aboriginal and Torres Strait Islander health workers and health practitioners in primary health care.

e. Detail specific steps that primary care practices can take to integrate Aboriginal and Torres Strait Islander health workers.

f. Include details of any workforce incentives for practices hiring Aboriginal and Torres Strait Islander health workers and health practitioners, as specified in Recommendation 9.

g. Work towards a national scope of practice (aligned with health assessment item 715 for Aboriginal and Torres Strait Islander people) for Aboriginal and Torres Strait Islander health workers and health practitioners.

Rationale 13

This recommendation focuses on investing in high value care and promoting the value of Aboriginal and Torres Strait Islander health workers and practitioners. It is based on the following:

- Aboriginal and Torres Strait Islander health workers and health practitioners are well positioned to provide culturally safe, comprehensive primary health care services to Aboriginal and Torres Strait Islander peoples (Refer to Recommendation 9).
- Limited awareness of the roles of Aboriginal and Torres Strait Islander health workers and health practitioners (and the differences between these roles) within primary health care services affects the ability of these health professionals to reach their full potential.
- There is a lack of understanding around the scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners. This results in work positions that do not accurately reflect the training of the health professional and do not always provide the appropriate clinical supervision to up-skill. Aboriginal and Torres Strait Islander health workers and health practitioners feel undervalued in their roles because of this lack of understanding (21).
- The Reference Group agreed that an awareness campaign would improve community responsiveness, which in turn would improve the integration of Aboriginal and Torres Strait Islander health workers and health practitioners into primary health care services in Australia.
- The Reference Group recognises that the recommendation to include Aboriginal and Torres Strait Islander health practitioners in the referral form for allied health professionals following a health assessment (item 715) would help to increase awareness of their role and scope of practice.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 13 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports this recommendation in principle, but agrees the proposal presented is outside the remit of the MBS Review.

Data infrastructure

Recommendation 14 - Establish an MBS data governance, reliability and monitoring group to provide guidance and oversight of Aboriginal and Torres Strait Islander peoples' MBS claims data to ensure accuracy

The Reference Group recommends the following changes to improve awareness about, and the transparency and use of, data related to Aboriginal and Torres Strait Islander peoples identification and associated service usage:

a. Ensure that considerations around Aboriginal and Torres Strait Islander peoples' data sovereignty and governance are a feature of future data access and use processes for Government and non-government parties.

b. Link MBS Voluntary Indigenous Identifier (VII) data with other administrative/routinely collected data where appropriate.

c. Ensure appropriate analysis and reporting is undertaken over time.

d. Ensure that evidence for improving uptake is incorporated into any policy decision-making process and is provided by people with relevant expertise.

e. Set a target to lift the percentage of Aboriginal and Torres Strait Islander peoples self-identifying as Indigenous in MBS data sets to 100 per cent.

f. That, where appropriate, these changes should be mirrored in the PBS.

Rationale 14

This recommendation focuses on ensuring that practice and implementation is informed by high quality evidence. It is based on the following:

- A number of articles have been published on enablers and barriers that affect Aboriginal and Torres Strait Islander peoples' access to MBS items and health care more generally (22; 23; 24). Several articles have specifically focused on Aboriginal and Torres Strait Islander peoples' health assessments. The reliability of data sets across Aboriginal and Torres Strait Islander health is a long-standing concern.
- MBS claims for Aboriginal and Torres Strait Islander peoples are estimated based on people voluntarily identifying as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander during the process of registering or renewing their Medicare registration (the VII). Recent estimates suggest that between 60 and 70 per cent of Aboriginal and Torres Strait Islander peoples have indicated their Indigenous status in the Medicare registration or renewal process.
- Medicare data specific to Aboriginal and Torres Strait Islander peoples is not easily accessible for analysis to monitor and track progress or change over time. item 715 is the exception; it is the only MBS item specific to Aboriginal and Torres Strait Islander peoples, and data on item 715 claims is publicly accessible (for example, see the Australian Institute of Health and Welfare Indigenous health check data tool) (25). Use of item 715 (and its predecessor items) has increased over time, but growth in health checks has flattened in recent years (25).
- The Reference Group noted the value of collecting better data on Indigenous status to help identify the reasons for low uptake of services and develop better solutions to improve the use of MBS services across all items.
- While implementing Aboriginal and Torres Strait Islander peoples' data governance is a new approach in Australia, there are international examples. In Canada, a data governance agreement between First Nations and the Ontario government enabled the Indigenous data file to be linked with a rich array of population-level health administrative data sources. This data linkage project has resulted in the creation of the largest First Nations health research study cohort in Canada (n = 200,000), which is being used by the Chiefs of Ontario for disease surveillance and evaluation of health services.
- Aboriginal and Torres Strait Islander peoples' data governance can be achieved by ensuring that institutions that conduct data linkage and research using administrative and routine data collections have appropriate data governance mechanisms in place (26).
- These improvements should be aligned with the 2006 Australian Health Ministers' Advisory Council National Aboriginal and Torres Strait Islander Health Data Principles.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 14 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports the need for robust and effective data to inform appropriate service planning, and in the context of Aboriginal and Torres Strait Islander Health notes that culturally appropriate engagement and governance will be needed. While the Taskforce is supportive, it notes such a framework extends beyond the MBS as a single entity and therefore beyond the remit of this Review.

The Taskforce also supports the idea of a data governance framework, noting enhanced identification would assist greatly with improved data quality and subsequent better patient outcomes, but agrees that this work would likely need to happen in a wider context than the MBS. Further work on the mechanisms for how this work would be undertaken should be explored.

Revenue generated by the 19(2) Directions for state and territory clinics

Recommendation 15 - Ensure that all MBS revenue generated from the 19(2) Directions for state and territory clinics, funded under the Indigenous Australians' Health Programme, delivering primary health care to Aboriginal and Torres Strait Islander peoples is invested back into primary health care services

The Reference Group recommends:

a. ensuring all MBS revenue generated from the 19(2) Directions for state and territory clinics, funded under the Indigenous Australians' Health Programme, delivering primary health care to Aboriginal and Torres Strait Islander peoples is invested back into primary health care services,

b. requiring state and territory governments to provide annual reports to their respective Aboriginal and Torres Strait Islander Health Partnership Forums on generated MBS income, with a corresponding proposal for how the additional revenue will be allocated each year into Aboriginal and Torres Strait Islander primary health care, and

c. financial reports be provided to DoH, detailing total Aboriginal and Torres Strait Islander primary health care grant expenditure and MBS income and expenditure.

Rationale 15

This recommendation focuses on ensuring that adequate funding for high-value primary care services is available to Aboriginal and Torres Strait Islander peoples. It is based on the following:

- In 1995-96, 2.19 per cent of all Australian recurrent health expenditure was on Aboriginal and Torres Strait Islander peoples, only 8 per cent higher per capita than for other Australians. In addition to this, a disproportionate amount of this money is spent on expensive, end-stage, hospital or similar care. On the other hand, for every $1 that non-Aboriginal and Torres Strait Islander peoples accessed through Medicare, Aboriginal and Torres Strait Islander peoples receive 27 cents. For every $1 that non-Aboriginal and Torres Strait Islander peoples accessed from the PBS for essential drugs, Aboriginal and Torres Strait Islander peoples accessed 22 cents. Even when grant funding through the then Office of Aboriginal and Torres Strait Islander Health Services was taken into account, the level of primary health care expenditure for Aboriginal and Torres Strait Islander peoples is still approximately $100 per person per year less than the national average (about $600 per person per year) (27).
- In addition, this lack of expenditure on primary health care must be seen in the context of the vastly greater Aboriginal need, as demonstrated by mortality and morbidity statistics. Measured against need, expenditure on Aboriginal and Torres Strait Islander health is clearly inadequate.
- In order to address this, in 1996, the Commonwealth Government enacted legislation that enables salaried GPs in Aboriginal Community Controlled Health Services (ACCHS) to access the MBS through clause 19(2) in the Health Insurance Act. This has become known as the 19(2) Direction.
- A key part of the 19(2) Direction was the requirement that all funds generated from the MBS were returned to the primary health care service in which they were generated, for the purpose of enhancing the primary health care services being provided to Aboriginal and Torres Strait Islander peoples. This was to ensure that there was a net gain in community based primary health care expenditure.
- In the early 2000s, the 19(2) Direction was extended to include salaried GPs working in Aboriginal and Torres Strait Islander primary health care employed by state and territory governments.

- As part of this, state and territory governments were required to submit annual reports to their respective Indigenous health planning fora on generated MBS revenue and how this was being reinvested back into primary health care. This system worked well for a few years and then ended, as it was felt that state and territory governments no longer required it. Unfortunately, it is claimed that this has enabled a return to significant risk of cost shifting within some jurisdictions, as MBS revenue increases are offset by reductions in grant funding for primary health care. This could imply that there is then no net gain in access to primary health care expenditure for Aboriginal and Torres Strait Islander peoples.
- As systems are developed within primary health care services to improve access to the MBS for Aboriginal and Torres Strait Islander peoples, it is important to ensure that the additional MBS revenue generated through improved access leads to additional community based primary health care services for Aboriginal and Torres Strait Islander peoples. This process should be transparent and accountable to both Aboriginal and Torres Strait Islander communities, who are the patients who own the MBS entitlement and service providers, as this increases health professionals' level of commitment to ensuring that services are properly claimed under the MBS in busy primary health care services.
- If additional funds are not perceived to lead to increased services, it creates a disincentive among salaried health professionals to do the additional work required to claim Medicare. Aboriginal and Torres Strait Islander peoples could then miss out, as the benefit is their right.
- Aboriginal Community-Controlled Health Services are based in their local community and subject to extensive financial auditing and reporting under the Indigenous Australians Health Programme. They also operate with the Corporations (Aboriginal and Torres Strait Islander) Act 2006 (CATSI Act) and regulations by the Office of the Register of Indigenous Corporations (ORIC) as well as the Corporations Act 2001. This degree of transparency within funding allocations at the community level may not always be as evident for individual health centres within a state or territory operated health service.
- The Reference Group discussed transparency with state and territories where funds can be consolidated into larger health service revenue which can make accountability of local reinvestment difficult.

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 15 – Not endorsed for Government consideration

The Taskforce agrees it is not within the remit of the MBS Review to make recommendations on funding allocation or how revenue is used.

Social and emotional well-being support for Aboriginal and Torres Strait Islander peoples

Recommendation 16 - Enhance social and emotional well-being support for Aboriginal and Torres Strait Islander peoples through an MBS rebate for social and emotional well-being support services delivered by accredited practitioners

The Reference Group recommends exploration of accredited practitioners which deliver social and emotional well-being support services which could include:

a. Community health and mental health workers (sometimes referred to as social and emotional well-being workers),

b. Care coordinators, and

c. Traditional and spiritual healers e.g. Ngangkari.

Rationale 16

This recommendation focuses on providing high-value care through increased access to social and emotional well-being support for Aboriginal and Torres Strait Islander peoples. It is based on the following:

- In broad terms, social and emotional wellbeing is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. It is a holistic concept which results from a network of relationships between individuals, family, kin and community. It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual (28).
- There is a complex array of environmental, social, economic, cultural and historical factors that influence and determine the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These include negative life events such as unresolved grief and loss, trauma and abuse, domestic violence, substance misuse, physical health problems, identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism, discrimination, and social disadvantage (29).
- Social and emotional wellbeing problems are distinct from mental health problems and mental illness, although they can interact with and influence each other. Even with good social and emotional wellbeing, people can still experience mental illness. Further, people with a mental health problems or mental illness can live and function at a high level with adequate support and they continue to have social and emotional wellbeing needs (30).
- Where possible, Aboriginal and Torres Strait Islander client management and treatment should be provided by a social and emotional wellbeing team. In order to achieve this, action area one of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2017-2023* requires an effective and empowered mental health and social and emotional wellbeing workforce (30). This suggests an appropriate social and emotional well-being team for Aboriginal and Torres Strait Islander peoples would include:
    - community workers
    - health workers
    - mental health workers
    - care coordinators, and
    - traditional and spiritual healers e.g. Ngangkari (31).
- Social and emotional wellbeing provides a foundation for effective physical and mental health promotion strategies. Promoting social and emotional wellbeing is about maximising the benefits of the protective factors that connect and support wellbeing, while minimising exposure to risk factors and particularly those that are also risk factors for mental health conditions (30).

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 16 – Not endorsed for Government consideration

The Taskforce supports this recommendation in principle and recognises the critical importance of support for social and emotional well-being of Aboriginal and Torres Strait Islander people but agrees that the proposal presented is outside the remit of the MBS Review.

Culturally safe health services

Recommendation 17 - Promote culturally safe health services for Aboriginal and Torres Strait Islander peoples to all health providers

The Reference Group recommends promoting culturally safe health services for Aboriginal and Torres Strait Islander peoples to all health providers.

Rationale 17

This recommendation focuses on improving access for Aboriginal and Torres Strait Islander peoples to all health services by improving cultural safety. It is based on the following:

- Aboriginal and Torres Strait Islander peoples are often reluctant to access health services because of discrimination, misunderstanding, fear, poor communication and lack of trust in service providers (32).
- It is important to recognise that the mainstream health system in Australia is based on a western biomedical model of care that does not account for the holistic view of health recognised and preferred by Aboriginal and Torres Strait Islander peoples (33).
- Historical experiences, coupled with personal and family experiences of institutionalised racism and disrespectful communication, contribute to a lack of trust in the system today and at times an unwillingness to engage with health care services.
- Racism is a Social Determinant of Health and a major cause of ill health in Aboriginal and Torres Strait Islander people. Racism, in all its forms, affects Aboriginal and Torres Strait Islander people by increasing blood pressure leading to long term cardiovascular disease damage, creating anxiety and depression (34).
- It is imperative that the health system delivers a culturally safe service, free of racism, within an intergenerational trauma informed environment.
- As a consequence, understanding and accommodating the cultural needs of Aboriginal and Torres Strait Islander patients can help provide safe and respectful services where patients, their families and other community members feel comfortable to engage with and receive care.
- Improving the cultural safety of a health service (35) can include:
    - increased access to the health service organisation by Aboriginal and Torres Strait Islander peoples
    - greater patient perceptions and experiences of care within the health service organisation
    - increased ability of patients and families to be involved in health care
    - improved wellbeing of the Aboriginal and Torres Strait Islander workforce through the reduction of racially discriminatory practices
    - improved equality and reduced disparity of health outcomes
    - greater cultural capability, which could benefit all vulnerable or culturally and linguistically diverse patients
    - increased understanding of Aboriginal and Torres Strait Islander health issues, health needs, and the complex personal experience of individuals, families and communities

- increased understanding of the diversity of Aboriginal and Torres Strait Islander peoples and communities
- reduced stress for the organisation's Aboriginal and Torres Strait Islander workforce from a reduction in racially discriminatory practices, and subsequent reduction in their vicarious trauma, cultural load and isolation, and
- increased recruitment and retention of the Aboriginal and Torres Strait Islander workforce.

- The Australian Health Practitioner Regulation Agency (AHPRA), on behalf of the National Scheme Aboriginal and Torres Strait Islander Health Strategy Group, is coordinating a Statement of Intent. Its aim is to ensure Aboriginal and Torres Strait Islander peoples have access to health services that are culturally safe and free from racism so that they can enjoy a healthy life, equal to that of other Australians, enriched by a strong living culture, dignity and justice (36).

Aboriginal and Torres Strait Islander Health Reference Group Recommendation 17 – Objective supported but an alternative (non-MBS) mechanism is recommended

The Taskforce supports this recommendation in principle and the importance of access to health services for Aboriginal and Torres Strait Islander peoples but agrees that the proposal presented is outside the remit of the MBS Review.

The Taskforce notes these issues are wider than just the MBS and should be considered across the entire healthcare system.

4.3.4 Aboriginal and Torres Strait Islander Health Reference Group Stakeholder Impact Statement

Both consumers and Aboriginal and Torres Strait Islander health professionals are expected to benefit from the recommendations in this report. In making its recommendations, the Reference Group's primary focus was ensuring consumer access to high-quality and culturally appropriate health services. The Reference Group also considered each recommendation's impact on Aboriginal Torres Strait Islander health professionals to ensure that it was fair and reasonable.

Consumers will benefit from the Reference Group's recommendations through improved access to higher quality health services that complement primary care stewardship, particularly in preventive health, chronic disease management, Aboriginal and Torres Strait Islander health worker services and high-quality, culturally appropriate group therapy, by:

- **Improved access to allied health services:** The Reference Group has recommended expanding the number of MBS-funded allied health consultations and enabling bulk-billing incentives to be billed in conjunction with these services for Aboriginal and Torres Strait Islander patients. This may directly motivate providers to increase their rate of bulk billing and increase access to services.
- **Culturally safe and appropriate services:** The Reference Group's recommendations to allow group treatment follow up services, allow Aboriginal and Torres Strait Islander health workers and nurses to provide certain services, ensure assessment templates are updated and synchronous with best practice, and to investigate the future role of non-registered Aboriginal and Torres Strait Islander health professionals all support more culturally safe and appropriate services.
- **Invest in the growth, resourcing and awareness of Aboriginal and Torres Strait Islander health services:** The Reference Group's recommendations to invest in growing and broadening the Aboriginal and Torres Strait Islander health workforce, building community awareness into the roles

and scopes of Aboriginal and Torres Strait Islander health workers and practitioners, establishing a MBS data governance group, and ensuring MBS revenue generated from the 19(2) Direction for Aboriginal and Torres Strait Islander peoples is reinvested into primary health care services all support a more effective and accessible health service.

Aboriginal and Torres Strait Islander health professionals would benefit from the Reference Group's recommendations through acknowledgement of their roles, particularly in rural and remote communities, a more accurate representation of their scope of practice being reflected in the MBS, and through the increased financial recognition of the care they provide. Aboriginal and Torres Strait Islander health professionals more broadly, would benefit from the Reference Group's recommendations by having increased choice in working models and support in training and community awareness of their roles.

Consumers, Aboriginal and Torres Strait Islander health professionals and the Australian health care system would benefit from overall increased investment in Aboriginal and Torres Strait Islander health, particularly in Aboriginal and Torres Strait Islander health research and future models of Aboriginal and Torres Strait Islander health workforce planning. These benefits would accrue from high-quality, cost-effective prevention and treatment outcomes that benefit patients and Aboriginal and Torres Strait Islander peoples both now and into the future, as part of the health system's commitment to closing the health gap for Aboriginal and Torres Strait Islander peoples.

4.4 Allied Health Reference Group

4.4.1 Allied Health Reference Group's Areas of Responsibility

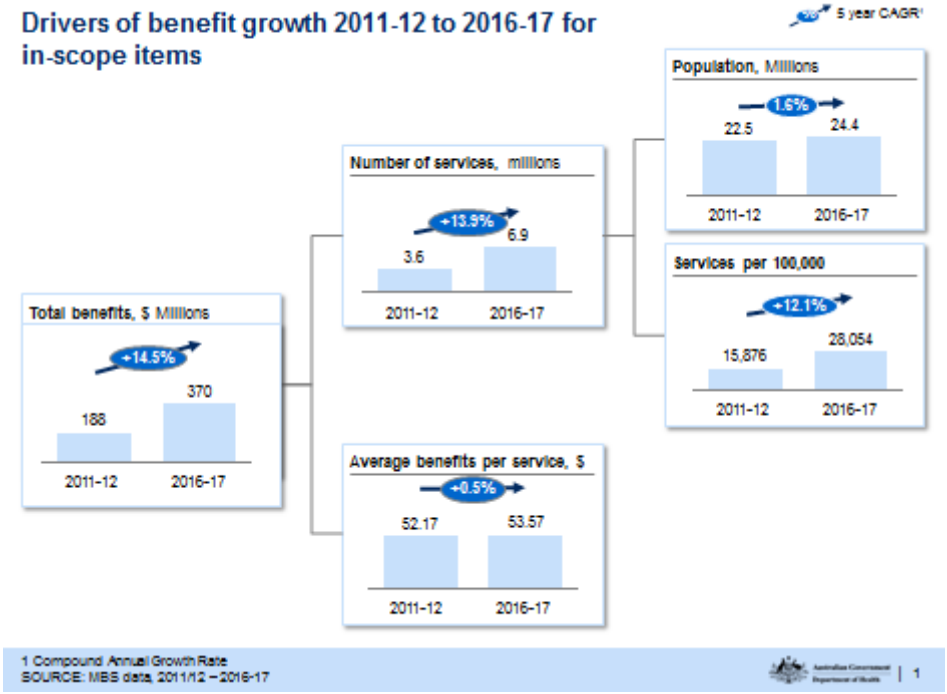
A list of all items reviewed by the AHRG can be found at Appendix B.

The AHRG reviewed 26 MBS items in three main subgroups:

- M3 – allied health individual services, items 10951–10970,
- M9 – allied health group services, items 81100–81125, and
- M10 – autism, pervasive development disorder and disability services, items 82005–82035.

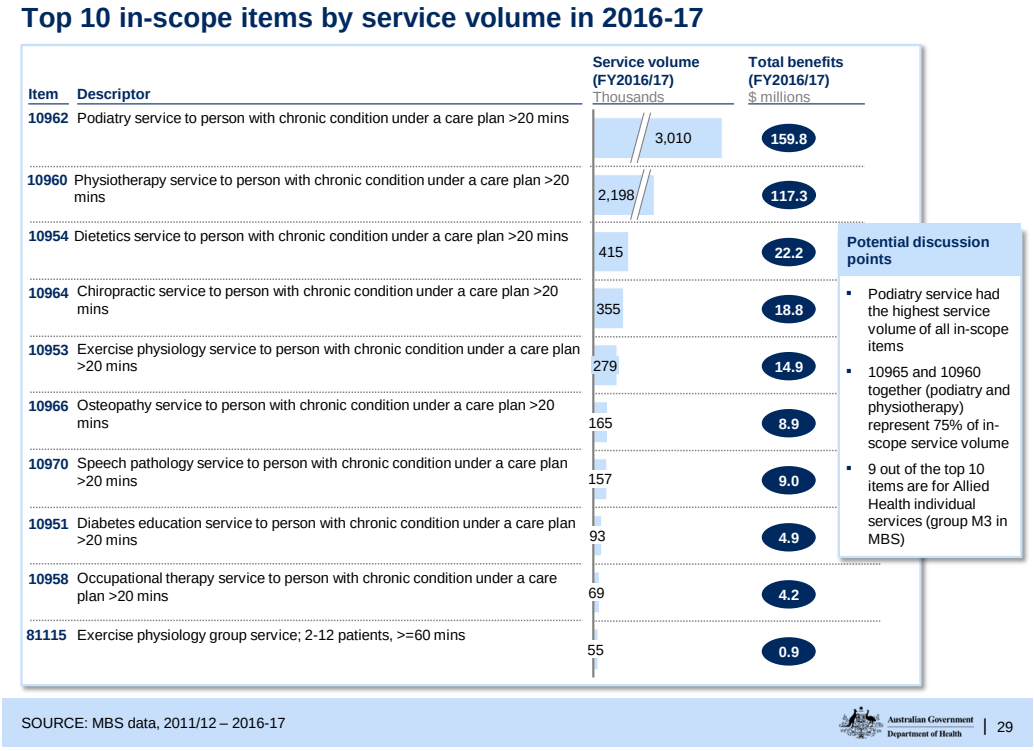
In 2016-17, these items accounted for approximately 6.9 million services and $370 million in benefits. Over the past five years, service volumes have grown by 12.7 per cent compounded annually (Figure 16).

Figure 16: AHRG – Drivers of benefit growth (2011-12 to 2016-17) for in-scope items



In 2016-17, podiatry had the highest service volumes of all in-scope items (3,010,000 services), with an approximate benefit cost of $159.8 million (Figure 17).

Figure 17: AHRG – Top 10 in-scope items by service volume (2016-17)



4.4.2 Allied Health Reference Group's Review Approach

The AHRG completed a review of its items across four full meetings, over a four month period of time, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including

- data on utilisation of items (services, benefits, patients, providers and growth rates),
- service provision (type of provider, geography of service provision),
- patients (demographics and services per patient),
- co-claiming or episodes of services (same-day claiming and claiming with specific items over time), and
- additional provider and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through medical and allied health journals and other sources, such as professional associations.

Main themes

During its review, the AHRG identified several themes that are relevant not just to the recommendations in this report, but also to the current challenges and future directions of allied health care in Australia. The AHRG agreed that there are opportunities to:

- **Expand allied health involvement in primary care.** There are opportunities to strengthen primary care teams by involving allied health professionals more frequently, and by enabling closer, more comprehensive communication. Better integration of allied health into primary care is likely to improve

clinical outcomes and satisfaction for consumers. Recommendation 16 expands on how communication between medical practitioners and allied health professionals can be improved.

- **Improve access to allied health for rural and remote populations.** There are far fewer allied health professionals in rural and remote regions, compared to metropolitan areas. The AHRG agreed that there is a need to expand the allied health professional workforce in these areas, and to use remote care delivery models to fill this gap (for example, see Recommendation 14 on the role of telehealth in allied health care).
- **Enhance preventive care and health promotion using allied health.** There is an opportunity to prevent the occurrence, or delay the onset, of chronic conditions (primary prevention) by facilitating access to appropriate allied health services for individuals with identifiable risk factors. The AHRG agreed that this opportunity should be seized and linked to the broader approach to preventive health care in Australia, and the approach to do so should be based on a sound evidence base.
- **Strengthen the evidence base for allied health.** The AHRG agreed that there is an opportunity and a need to build an allied health research base (Recommendation 13) to target allied health interventions to provide cost-effective, high-value care.
- **Improve data collection and transparency for allied health use across Australia.** There is limited available data linking allied health use across funding streams and patient journeys in Australia. Improving this data would enhance PHN, state and federal understanding of the drivers of patient choice and clinical outcomes, as well as strengthening decision-making. It could also lead to cost savings and improved patient outcomes in the medium to long term.

Consumer impact

The AHRG has developed recommendations that are consistent with the Taskforce's objectives, with a primary focus on ensuring that patients have access to high-quality allied health care.

The AHRG's recommendations will benefit consumers in the following ways.

- **Improving service quality.** Introducing initial assessment appointments for allied health services referred through TCAs will ensure that allied health services are performed in line with best-practice guidelines. This will ensure that patients are appropriately assessed during their first attendance with an allied health professional.
- **Ensuring consumers are adequately informed.** Enhancing communication between consumers, GPs and allied health professionals (Recommendation 16) will ensure that patients are adequately informed about their current and future treatment, and will facilitate consumers' involvement as active participants in their care. This recommendation will also increase transparency for patients on the number of MBS-rebated appointments they can access under their chronic disease management plan, and any out-of-pocket fees that may be payable to allied health care professionals.
- **Increasing access to services.** Increasing the number of allied health appointments for eligible patients with highly complex care requirements under chronic disease management plans.
- **Providing flexibility in service delivery and peer support.** Expanding group therapy (after a systematic review of M9 items) will provide consumers with flexibility in the way that allied health care is provided, and enable more peer support. This will provide the option of having therapeutic interventions in group sessions if the consumer desires.
- **Ensuring care is evidence-based.** Building an allied health research base will ensure that current and future allied health services delivered to consumers is informed by an evidence base.

4.4.3 Allied Health Reference Group Recommendations

The Reference Group has recommended significant amendments to existing items and the creation of new items. These recommendations ensure that the MBS aligns with current clinical guidelines and provides access to high-quality allied health services. The final recommendations in this report (Recommendations 13–18) suggest ways to improve community-based allied health care in Australia.

The Reference Group's recommendations aimed to address nine broad themes:

- Ensure that clinical services align with best-practice guidelines.
- Increase access to allied health in primary care.
- Ensure that the list of eligible allied health professionals under the MBS reflects contemporary practice.
- Facilitate group-based allied health therapy where clinically appropriate.
- Ensure that patients with an ASD, CND or disabilities have adequate access to high-quality allied health services.
- Strengthen evidence base for the provision of allied health care in Australia.
- Improve access to allied health services in rural and remote areas.
- Change the delivery model and focus of allied health in Australian primary care.
- Improve communication between allied health professionals and other health care professionals.

Short term recommendations

The Reference Group's short term recommendations are described below.

1. Introduce initial assessment appointments (of more than 40 minutes) for allied health professionals.
2. Increase the number of allied health appointments under team care arrangements (TCAs; item 721 and 723) by stratifying patients to identify those with more complex care requirements.
3. Introduce a new item for orthotic or prosthetic services under the MBS.
4. Conduct a systematic review of the evidence for group allied health interventions to inform future models of care.
5. Introduce a practice incentive payment for allied health professionals who provide group therapy under items 81105, 81115 and 81125.
6. Update the M10 descriptor to encompass ASD, CND and eligible disabilities.
7. Increase the number of assessment items available for children with a potential ASD, CND or eligible disability diagnosis.
8. Allow up to two assessment items to be used for case conferencing for children with a potential ASD, CND or eligible disability diagnosis.
9. Allow M10 treatment items to be delivered as group therapy under the Helping Children with Autism (HCWA) program.

10. Include patients with severe speech/language disorders in the list of eligible disabilities under M10 items.
11. Increase the ASD, CND and eligible disability assessment and treatment age to 25.
12. Allow inter-disciplinary referral between allied health professionals during the assessment phase for eligible disabilities, CND and ASD.
13. Expand the role of telehealth in allied health care.
14. Add non-dispending pharmacists to the list of eligible allied health professionals under the MBS.

Longer-term recommendations

The Reference Group was also tasked with exploring longer-term issues. The following recommendations have been classified as longer-term recommendations as they require preliminary work and trial prior to implementation; they are not considered to be of lesser importance.

15. Build an allied health research base.
16. Pilot non-fee-for-service allied health payment models.
17. Enhance communication between patients, allied health professionals and general practitioners (GPs).
18. Expand the role of allied health in the Australian public health care system.

Below are the recommendations from the AHRG's report. The recommendations are intended to improve community-based allied health care encouraging best practice to improve patient care.

Allied health individual services under chronic disease management plans (M3 items)

Recommendation 1 – Encourage comprehensive initial assessments by allied health professionals

The AHRG recommends:

a. creating a new item (109AA) for an initial allied health appointment of at least 40 minutes,

b. placing the following restrictions:

   (i) claiming to the first attendance for a unique presentation and a maximum of one per patient, per provider, per calendar year,

   (ii) claiming by allied health professionals in the same practice providing care for the same unique presentation, and

   (iii) co-claiming with M3 items (10950–10970) and M9 items for assessing the suitability of group sessions (81100, 82110 and 81120),

   and

c. the proposed item descriptor as follows:

New item 109AA – example text

Initial allied health service provided to a person by an eligible allied health practitioner, if:

a) the service is provided to a person who has:

(i) a chronic condition, and

(ii) complex care needs being managed by a medical practitioner (including a GP, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan, and

b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs, and

c) the person is referred to the eligible allied health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department, and

d) the person is not an admitted patient of a hospital, and

e) the service is provided to a patient for the first attendance for a unique presentation

f) the service is provided to the person individually and in person, and

g) the service is of at least 40 minutes duration, and

h) an initial assessment service has not already been provided by an allied health practitioner of the sample profession (e.g. physiotherapy) for the same unique presentation in the same practice (where it is practical to gather this information), and

i) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c)

j) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit

to a maximum of one service per eligible allied health practitioner per patient per year.

Not to be claimed with items 81100, 82110, 81120 or 10950–10970.

and

d. the proposed explanatory notes as follows:

New item 109AA Explanatory note – example text

A unique presentation includes:

a) A primary (presenting) complaint for which the allied health professional has not seen the patient before.

b) A primary (presenting) complaint for which the allied health professional has seen the patient before, but where a significant change in the quality or severity of the complaint necessitates reassessment.

Allied health professionals in the same practice are expected to share information about the initial appointment findings, where clinically relevant.

Rationale 1

This recommendation focuses on providing high-quality care to patients, in line with professional standards. It is based on the following:

- It is standard practice for allied health professionals to undertake initial assessments.
- All allied health professionals governed by AHPRA must meet and abide by their specific board's regulations and codes to maintain registration. Service descriptors and scopes of practice set out by their associations facilitate meeting these requirements.
- Professional associations that are members of the National Alliance of Self Regulating Health Professions (NASRHP) set service descriptors and scopes of practice for their individual professions to align with NASRHP standards.
- Service descriptors set out by allied health professional associations distinguish between initial assessments and subsequent assessments. Examples of which can be drawn from the following references (1; 2; 3; 4; 5; 6). Notwithstanding some differences in structure across allied health professions, initial assessments tend to include the following activities:
    - taking a more thorough history (as the patient is often new),
    - conducting a bio-psycho-social assessment,
    - reaching a diagnosis, and
    - setting goals and planning treatment.
- The AHRG agreed that these activities are not required (or take less time) in subsequent consultations.
- Differences between initial and subsequent appointments are already reflected in the private practice billing structure across all professions, and by the following subsidy schemes:
    - Return-to-work schemes across Australian states (7),
    - Private health insurance company rebate structures (8; 9),
    - The DVA model (10), and
    - Motor and road traffic vehicle accident insurance schemes (11).
- The AHRG agreed that creating an item for initial appointments under CCMPs would promote best-practice care in the MBS.
- The AHRG agreed that initial appointments should take at least 40 minutes, based on clinical experience and analysis of allied health professional service descriptors.
- The AHRG further agreed that creating a new item for initial assessments would better align Schedule fees with the duration of service provided.
- To ensure that item 109AA is used in clinically appropriate circumstances, the AHRG has recommended the following restrictions:
    - Cap item 109AA claims at one per patient, per provider, per year.

- The AHRG agreed that there should be an annual restriction of one claim per patient, per provider, per year in order to limit low-value use of item 109AA.
    - Restrict co-claiming of item 109AA with routine M3 and M9 appointments.
- The AHRG agreed that there are no circumstances in which it would be appropriate to claim both an initial and a routine attendance together. The AHRG also agreed that there are no circumstances in which it would be appropriate to claim both an initial appointment and an M9 item for assessment of suitability for group therapy.
    - Restrict claiming to services provided for the first attendance for a unique presentation.
- The AHRG agreed that initial assessments provide high-value care for unique presentations (i.e. the first time seeing a patient with a given presenting complaint) because they provide more time in which to take an in-depth history, perform a comprehensive examination, identify a diagnosis and create a management plan.
- The AHRG agreed that once the allied health professional has seen a patient for a given presenting complaint, an additional initial assessment for this presentation would be high value for the patient if there has been a significant change in the degree of severity of the presenting complaint.
    - Restrict claiming by allied health professionals in the same practice providing care for the same unique presentation.
- The AHRG agreed that allied health professionals within the same practice are expected to share relevant clinical information about a patient's initial assessment if the patient changes allied health professionals within a practice.
- The AHRG further agreed that the content of initial assessments is sufficiently different between allied health professions that it is not appropriate to restrict different types of allied health professionals in the same practice from claiming item 109AA for a given patient. For example:
    - A physiotherapist seeing a patient who has had an initial assessment within the past year with a different physiotherapist in the same practice cannot bill for item 109AA (unless it is for a different unique presentation).
    - A dietitian seeing a patient who has had an initial assessment within the past year with an osteopath in the same practice can bill for item 109AA.
- The AHRG agreed that use of this item should be reviewed in 12 to 24 months so that any abnormal claiming patterns can be analysed.

AHRG Recommendation 1 – Objective supported but referral to relevant research initiatives recommended

The Taskforce acknowledges the AHRG's recommendation encouraging allied health professionals to undertake comprehensive initial assessments in principle but agrees that there is not sufficient evidence to support the proposed new item in its current form. There is also concern around the impact creating a new item will have on the use of other items (i.e. subsequent attendances).

The Taskforce agrees that the following needs further exploration:

- the potential clinical benefit to patient needs,
- the impact on fee and out of pocket costs, and

- the appropriate fee structure to support an initial attendance (i.e. would time-tiering model be more appropriate?).

The Taskforce notes that it has made recommendations based on the work of the Specialist and Consultant Physician Clinical Committee to further address the disparities of initial and subsequent attendances through the development of a time-tiered model for attendance items. This work may in time determine appropriate approaches to assessing and supporting patients in receiving high-value care.

Recommendation 2 – Expand allied health involvement under team care arrangements

The AHRG recommends:

a. increasing the number of allied health appointments under GPMPs and TCAs by stratifying patients to identify those with more complex care requirements (items 721 and 723),

b. creating a follow-on piece of work that identifies and details a model to stratify patients with a GPMP who could benefit from additional allied health appointments While it is unlikely that one single assessment tool will be satisfactory, assessment to stratify patients should include:

   (i) Clinical judgement

   (ii) Co-morbidities

   (iii) Risk of deterioration in condition

   (iv) Impairment

   This work must include involvement of the allied health sector.

c. consideration of the following:

   (i) Patients identified under this stratification model could receive an additional envelope of appointments with an eligible allied health professional (for example, five or more) after accessing the first envelope of five appointments.

   (ii) Multiple stratification dimensions could be used, including:

   - The number of chronic conditions a patient has (defined by chronic conditions eligible for a GPMP).
   - The severity of the chronic conditions.
   - The discretion of the referring practitioner, based on the number of chronic conditions and/or the severity of those conditions.

   (iii) The follow-on piece of work should test and identify the most appropriate stratification approach,

   and

d. implementation of the new model be phased, so that the effects of additional allied health appointments on health outcomes can be studied during a pilot period with consideration that this process could include:

   (i) A pilot with a limited sample size of the population receiving TCAs.

   (ii) A study of the health outcomes of patients in this pilot program over a multi-year period, compared with patients with TCAs who are not in the pilot patient sample (control group).

(iii) Targeted expansion of the increased number of allied health appointments to the rest of the chronic disease patient population in Australia, based on the findings from the pilot.

Rationale 2

This recommendation focuses on ensuring that the MBS provides access to high-quality, high-value care for consumers and the health care system. It is based on the following:

- The AHRG agreed that a set of five MBS-funded allied health appointments is often insufficient to adequately treat patients with chronic conditions. It noted the following problems:
    - MBS data shows that 26 per cent of patients with TCAs use all five allied health appointments available under their care plans. This means that approximately 575,000 patients every year (based on 2016 data) reach their annual cap of MBS-funded allied health appointments and may be unable to access allied health services.
    - Allied health services under TCAs are shared between allied health professionals, meaning that a patient often does not get a Schedule fee for seeing a given allied health professional more than one to three times in a year (unless they pay out of pocket).
- Patients who require more than five allied health appointments are often not adequately supported by other sources of funding. States, territories and PHNs: Demand-driven waiting times often restrict patient access, and patients are prioritised based on medical condition, not on capacity to pay. Forty-five per cent of Australians do not have private health insurance for general treatment (including allied health services) (12).
- Evidence indicates that allied health interventions are effective and cost-efficient (including mitigating downstream health care costs) in managing a range of chronic health conditions. However, there is limited evidence regarding the optimal annual number of allied health attendances for Australian patients with chronic disease. This has been complicated by the diverse range of treatments provided to patients with chronic disease, as well as the range of presenting conditions.
- The AHRG agreed that this recommendation represents an opportunity to provide more allied health appointments to patients with highly complex conditions under TCAs, while studying the effects of this increase on outcomes through phased implementation (via a pilot). The AHRG agreed that both clinical outcomes and cost-efficiency (including hospitalisations) should be measured during this pilot phase.
- The AHRG agreed that there are several ways to stratify patients to identify those who may benefit from additional appointments, and that the follow-up piece of work should identify the most effective approach.

AHRG Recommendation 2 – Objective supported but referral to relevant research initiatives recommended

The Taskforce supports the rationale behind this recommendation, but agrees more research is needed to develop an appropriate evidence base on patient needs and the appropriate number of service (or appropriate model of care) to meet those needs.

The Taskforce suggests any research into the expansion of allied health under a stratification model for TCAs should include impacts on continuity of patient care and maintaining longitudinal care in collaboration with the patient's primary care provider (i.e. their GP).

Recommendation 3 – Improve access to orthotic or prosthetic services

The AHRG recommends:

a. creating a new item (109BB) in the M3 group for the delivery of orthotic or prosthetic services, lasting at least 40 minutes,

b. allowing this item to be claimed when referred by a GP as part of a chronic disease management plan (item 721), including TCAs (item 723),

c. specifying in the explanatory notes that eligible allied health professionals include prosthetists and orthotists,

d. capping the number of times this item can be claimed to once per patient, per calendar year, and

e. the proposed item descriptor as follows:

New item 109BB – example descriptor

Orthotic or prosthetic allied health service provided to a person by an eligible allied health practitioner, if:

a) the service is provided to a person who has:

   (i) a chronic condition, and

   (ii) complex care needs being managed by a medical practitioner (including a GP, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan

b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs, and

c) the person is referred to the eligible allied health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department, and

d) the person is not an admitted patient of a hospital, and

e) the service is provided to the person individually and in person, and

f) the service is of at least 40 minutes duration, and

g) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c).

h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit

to a maximum of one service per year.

Rationale 3

This recommendation focuses on providing high-quality care to patients with complex care requirements who are at risk of deterioration who, if left untreated, are likely to require hospitalisation. An example is a high risk limb ulcer that may lead to amputation. It is based on the following:

- Access to private orthotic and prosthetic services is limited to patients who can afford to pay the cost of the clinical service. Private health insurance rebates are available for prosthetic devices, but not for the clinical service.
- Patients who cannot pay for these services have access to publicly funded services through the public hospital system. However, the hospital service is in high demand, so programs stratify patients by risk. This means that there is a delay in getting the first appointment for patients with lower care requirements (who are often eligible for community care). For these patients, the wait can be several months, during which time their clinical condition can deteriorate. The patient may then present at a "crisis point" in their condition (13).
    - Services provided by orthotists and prosthetists have been shown to improve clinical outcomes in several health conditions such as diabetes (14; 15), stroke and other neurological conditions (16; 17; 18), and arthritis (19).
    - Early intervention in foot disease (especially for people with diabetes) is likely to reduce overall health care costs for patients (20).
    - The AHRG agreed that although podiatrists have a similar scope of practice, orthotists and prosthetists are uniquely positioned to provide orthotic and prosthetic services in complex cases. As such, the AHRG agreed that their inclusion in the MBS would improve clinical outcomes.
    - The AHRG agreed that the total cost of this recommendation is likely to be low, as orthotic and prosthetic services will likely be an (appropriate) substitute for podiatry appointments under M3 items.
    - There are 220 orthotists/prosthetists (in total) practicing privately in Australia (21), compared to 3,462 privately practicing podiatrists (22). This means that service volume is likely to be low.
    - The AHRG noted that state-funded equipment schemes are in place to fund orthoses or prostheses for patients with specific criteria, such as a functional disability. The specific gap in care is for clinical services to assess for suitability of orthoses or prostheses, and the AHRG has recommended an item to fill this gap. The AHRG acknowledged that there are other ways—outside the MBS and the remit of the AHRG—to increase the funding for community-based orthotic and prosthetic services across Australia but has chosen this as one way to improve service delivery.
    - The AHRG agreed that the Australian Orthotic Prosthetic Association's (AOPA) submission on this topic provides a detailed analysis of the evidence and the case for including orthotists and prosthetists, as per this recommendation (23).

AHRG Recommendation 3 – Objective supported but alternative funding (non MBS) mechanism recommended

The Taskforce acknowledges there may be a clinical need for this, but agrees alternative funding models should be considered noting integration with the NDIS and public hospital systems will be key for patient outcomes. Should inclusion in the MBS be considered in the future, appropriate MSAC process should be followed.

Allied health group services under chronic disease management plans (M9 items)

Recommendation 4 – Understand the effectiveness of group allied health interventions

The AHRG recommends:

a. conducting a systematic review of current evidence to support evidence-based expansion of group allied health interventions,

b. that this systematic review be conducted to specifically identify:

   (i) the clinical scenarios (across all eligible allied health professions under the MBS) in which allied health group interventions provide high-value care to patients, and

   (ii) The ideal ratio of participants and allied health professionals for group therapy (including whether there are different types of professionals—i.e. a multidisciplinary team) in each of these high-value clinical scenarios,

   and

c. the expansion of allied health group therapy be targeted based on the findings of this systematic review, by:

   (i) expanding patient eligibility for M9 MBS items, and

   (ii) accessing funding outside of the MBS.

Rationale 4

This recommendation focuses on ensuring that patients have access to high-quality clinical services. It is based on the following:

- The AHRG agreed that clinically appropriate group therapy is of high value for patients. Compared to individual therapy, group therapy:
  - Enhances socialisation and peer support.
  - Improves motivation and self-management.
  - Encourages patient independence while under clinical supervision.
  - Can be more cost-effective.
  - Can reduce waiting lists for services and help patients receive care faster.
  - Can enhance the delivery of integrated multidisciplinary care.
- M9 items under the MBS are currently limited to patients with type 2 diabetes. The AHRG agreed that there are benefits to providing group therapy in other patient cohorts. During its review, it noted that the following patient cohorts may benefit from multidisciplinary group-based allied health interventions.
- Patients with heart failure. Exercise-based rehabilitation programs have been shown to reduce hospitalisations and improve health-related quality of life for patients with heart failure (24). Dietitians are also recommended providers of group education sessions for heart failure, and for education and counselling regarding weight management and fibre, alcohol, saturated fat and/or caffeine intake (25).

- Patients with cancer. The Clinical Oncology Society of Australia recommends that exercise led by accredited allied health professionals should be integrated into standard cancer care (26). The Cancer Council of Victoria recommends including diet and exercise in group exercise programs (27).
- Children with speech and language delay. Group therapy and individual therapy have been shown to lead to similar outcomes (28).
- Patients receiving pulmonary rehabilitation. The AHRG notes that an application to expand group therapy for pulmonary rehabilitation has been submitted to the MSAC (29).
- A systematic review would allow for equitable and cost-effective expansion of allied health group therapy interventions.
- Implementation of the clinical care guidelines recommended in this systematic review could be achieved through the MBS, or outside the MBS through a non-fee-for-service structure.

AHRG Recommendation 4 – Objective supported but referral to relevant research initiatives recommended

The Taskforce acknowledges evidence on the value of group therapy and follow-up services, and supports improved access for patients, but agrees a fee for service model is not the best way to support delivery of these services due to variability in group definitions and types (e.g. the size of a group and the approach to the delivery of a service).

The Taskforce notes limitations in the fee-for-service model in promoting longitudinal care and addressing patient complexity, and agrees further research should be undertaken on evidence-based models of successful non-MBS group therapy. Such evidence could inform consideration of non-fee for service solutions.

Recommendation 5 – Incentivise group therapy for chronic disease management

The AHRG recommends introducing a practice incentive payment for allied health professionals who provide group therapy under items 81105, 81115 and 81125.

The impact of this incentive should be evaluated following a comprehensive trial period.

Rationale 5

This recommendation focuses on ensuring adequate access to high-quality allied health services for consumers. It is based on the following:

- The AHRG agreed that current group therapy items for type 2 diabetes are underused. MBS data shows that claims for exercise physiology group services are growing at 15 per cent per year, while claims for group diabetes education and dietetics services are decreasing at 13 per cent and 12 per cent annually, respectively.
- The AHRG agreed that group therapy items are underused because allied health professionals face barriers in organising and running group sessions. The following barriers limit access to group services for patients:
    - There are significant fixed costs associated with running group sessions—for example, the costs associated with renting or setting up a large room.
    - A significant time investment is required to organise the logistics to run group sessions.

- Allied health professionals need to have a large enough group to cover the costs of providing the service, including when patients cancel or do not attend sessions.

- The AHRG agreed that introducing a practice incentive payment for allied health professionals providing services under items 81105, 81115 and 81125 would increase the likelihood that they offer group therapy sessions, thereby increasing access for patients and providing a more beneficial modality for the delivery of this treatment.

AHRG Recommendation 5 – Objective supported but referral to relevant research initiatives recommended.

The Taskforce acknowledges evidence on the value of group therapy and follow-up services, and supports improved access for patients, but agrees a fee for service model is not the best way to support delivery of these services due to variability in group definitions and types (e.g. the size of a group and the approach to the delivery of a service).

The Taskforce notes limitations in the fee-for-service model in promoting longitudinal care and addressing patient complexity, and agrees further research should be undertaken on evidence-based models of successful non-MBS group therapy. Such evidence could inform consideration of non-fee for service solutions.

Allied health services for autism, pervasive developmental disorder and disability (M10 items)

Recommendation 6 – Improved access to paediatric allied health assessments

The AHRG recommends:

a. amending the item descriptor for M10 items to *Autism Spectrum Disorder (ASD), Complex Neurodevelopmental Disorder (CND) and Disability and remove Pervasive Developmental Disorder (PDD)*,

b. updating the M10 explanatory notes to reference the Diagnostic and Statistical Manual of Mental Disorders (DSM V) and incorporation of PDD under ASD in DSM V

c. the list of eligible disabilities for M10 items should be extended to include:

   (i) Foetal Alcohol Syndrome Disorder (FASD),

   (ii) Lesch-Nyhan Syndrome, and

   (iii) 22 g deletion Syndrome (previously Velocardiofacial Syndrome)

   and

d. consideration be given to updating the descriptor of M10 items, specifically MBS item 82030 and 82035, to include additional allied health practitioners (e.g. Dietetics and Exercise Physiology) who provide evidence-based interventions for persons with ASD, CND and Disability.

Rationale 6

This recommendation focuses on ensuring that the MBS provides adequate access to paediatric allied health assessments. It is based on the following:

- This recommendation provides an update to the clinical terminology and condition examples aligning M10 items with other MBS specialist paediatric complex plan items.
- Throughout the MBS Review process, stakeholders have contacted DoH seeking clarification on the existing MBS item terminology and in particular the inclusion of FASD and other CNDs. This recommendation is in line with the items currently under review by the Specialist and Consultant Physician Consultations and Psychiatry Clinical Committee.
- Following the MBS Review consultation process, stakeholders have communicated the need to update the descriptors of the M10 items to include additional allied health practitioners, including Dietetics and Exercise Physiology, who can provide evidence-based interventions to this target group.
- There may be ongoing work associated with this recommendation requiring further amendments ensuring all M10 item descriptors best encapsulate their targeted cohort and service provisions.

AHRG Recommendation 6 – Endorsed for Government consideration

The Taskforce supports this recommendation and the AHRG's rationale.

Recommendation 7 – Improve access to complex paediatric allied health assessments for children with a potential ASD, CND or eligible disability diagnosis

The AHRG recommends:

a. increasing the number of assessment items (82000, 82005, 82010 and 82030) available for children with a potential ASD, CND or eligible disability diagnosis,

b. the number of allied health assessment appointments available for a child with a potential ASD, CND or eligible disability diagnosis be increased from four per lifetime to eight per lifetime, and

c. a review by the referring practitioner be required between the first four and additional four appointments.

Rationale 7

This recommendation focuses on ensuring that the MBS provides adequate services to diagnose ASD and eligible disabilities and to form treatment plans (as per the MBS descriptors). It is based on the following:

- *National Guidelines for the Assessment and Diagnosis of Autism Spectrum Disorder in Australia* approved by the NHMRC recommends a progressive approach to diagnostic formulation, whereby additional clinical investigations are based on the clinical complexity of the individual.
- The Guidelines recommend an initial comprehensive needs assessment which comprises Allied health assessments of functioning and a medical evaluation. This determines treatment plans and whether the patient goes onto a diagnostic evaluation. For patients with complex or subtle presentations, accurate diagnosis requires a multidisciplinary consensus team. Eligible members of the consensus team, in addition to a medical practitioner, include Psychologists, Speech Pathologists and Occupational Therapists.
- The AHRG agreed, based on an overview provided by two members working in this field, that allied health professionals typically require more than two attendances (and often up to four) to adequately assess a child with potential ASD for diagnostic purposes. Four assessment appointments do not always allow for adequate allied health input to reach consensus on a team diagnosis.

- As per the item descriptors in the MBS, the assessment items are to assist with the diagnosis or to contribute to the treatment plan. Currently there are a maximum of four sessions across eligible allied health professionals for assessment for diagnosis and treatment planning. As recommended in the *National Guidelines for the Assessment and Diagnosis of Autism Spectrum Disorder* in Australia, a Comprehensive Needs Assessment for a treatment plan from Allied Health Professional Assessments forms part of the Diagnostic process.
- An important safeguard of this recommendation is that a review by the referring practitioner is required between the first four and additional four assessment appointments.
- The AHRG noted that assessment services are not provided under the National Disability Insurance Scheme (NDIS), and that the MBS provides an important service to eligible children.
- The items as per the descriptors in the MBS are to assist with the Diagnosis or to contribute to the treatment plan. Other children with eligible disabilities require multiple allied health assessments due to the complexity of the disability. To gain access to the NDIS and other government-funded supports, families are required to submit evidence from Allied Health Professional assessments of the complexity of the child's presentation and the required treatment plan.
- As a current example, the parents of a three year old child with Cerebral Palsy have paid for the following assessments for their child. Each assessment listed was conducted by an allied health practitioner who worked in a specialised field.
    - Speech Pathology – Paediatric Swallowing Assessment
    - Speech Pathology – Communication Device Assessment
    - Speech Pathology – Motor Speech Assessment
    - Occupational Therapy - Assessment for Home Modifications
    - Occupational Therapy - Assessment for Car Modification
    - Occupational Therapy - Assessment of Development (dressing, eating, toileting, upper body functions)
    - Physiotherapy - Aqua Therapy Assessment
    - Physiotherapy - Motor Development Assessment
    - Physiotherapy/Occupational Therapy – Equipment Prescription Assessment (wheelchair)
    - Orthotic Assessment
- To ensure equitable access to assessment services for patients with eligible disabilities, the recommended change to assessment items should apply to both ASD, CND and eligible disabilities under the MBS.

AHRG Recommendation 7 – Endorsed for Government consideration

The Taskforce supports this recommendation and the AHRG's rationale, but also emphasises the need for a referring practitioner as allied health professionals cannot independently diagnose disability.

Recommendation 8 – Encourage multidisciplinary planning for children with a potential ASD or eligible disability diagnosis

The AHRG recommends allowing up to two assessment items to be used for case conferencing for children with a potential ASD, CND or eligible disability diagnosis (items 82000, 82005, 82010 and 82030).

Note: Case conferencing involves the referring practitioner and other members of the multidisciplinary team assessing a child. The parent may also be present.

Rationale 8

This recommendation focuses on ensuring that the MBS provides adequate services to accurately diagnose ASD, CND and eligible disabilities. It is based on the following:

- National guidelines for ASD assessment (as highlighted in Recommendation 6) require the diagnostician to weigh input from an allied health diagnostician and other allied health informants (including allied health professionals) in making their diagnosis. Communication between the referring practitioner and allied health professionals is important in making an ASD diagnosis (30).
- The AHRG agreed, based on an overview provided by two members working in this field, that allied health professionals often undertake case conferences specifically to determine whether a child meets the Diagnostic and Statistical Manual, Fifth Edition (DSM-V) criteria for ASD or a different eligible disorder. It agreed that these interactions are an important part of the ASD diagnostic process and should be enshrined in the MBS.
- The AHRG agreed that new items are not necessary for this purpose. Allowing current assessment items (and those added through Recommendation 6 to be used for case conferencing would provide adequate capacity for allied health professionals to assess children and liaise with the referring practitioner.
- Case conferences would not require the child to be present, but the parents of the child may be invited to attend.
- To ensure equitable access to assessment services for patients with eligible disabilities, the recommended change to assessment items should apply to both ASD and eligible disabilities under the MBS.

AHRG Recommendation 8 – Endorsed for Government consideration

The Taskforce supports this recommendation and the AHRG's rationale.

Recommendation 9 – Improve access to M10 treatment items as group therapy

The AHRG recommends allowing M10 treatment items to be delivered as group therapy under the HCWA program, including:

a. allowing the 20 M10 treatment items for the HCWA program to be delivered as either group therapy (with two to four participants) or individual therapy,

b. requiring at least one allied health professional to be present for the full group session,

c. allowing all allied health professions to deliver these services when nominated on the care plan, and

d. specifying a minimum duration of 60 minutes for group sessions.

Rationale 9

This recommendation focuses on ensuring that the MBS provides access to flexible, high-value care to children with ASD. It is based on the following:

- Evidence indicates that group-based social skill interventions are at least as effective as individual therapy for patients with ASD. Miller et al. conducted a systematic review of 44 studies on group-based ASD therapy and identified significant evidence demonstrating the usefulness of social skills groups as an intervention for adolescents with ASD (31). Tachibana et al. showed that for pre-school children with ASD, both individual and group interventions showed significant effects (compared to the control condition) on overall outcomes of "reciprocity of social interaction towards others." (32).
- Group-based interventions provide social and support networks for families facing similar challenges.
- Children and adolescents need group opportunities to generalise social skills learnt in individual sessions to small, supported groups of peers. This is a stepping stone to using skills in larger groups, such as in kindergarten and at school. Children and adolescents also develop a social network and social supports in group treatment. Children and adolescents who have no friends often make long-term connections with other members in the groups.

AHRG Recommendation 9 – Objective supported through the National Disability Insurance Scheme

The Taskforce notes that responsibility for this recommendation now belongs with the NDIS, as the HCWA program is being transitioned to the NDIS (to be completed by 30 June 2020).

Recommendation 10 – Improve access to M10 items for patients with severe speech and language disorders

The AHRG recommends:

a. including patients with severe speech/language disorders in the list of eligible disabilities under M10 items,

b. the list of eligible disabilities for M10 items be extended to include:

   (i) Stuttering.

   (ii) Speech Sound Disorder (SSD) (includes phonology and childhood apraxia of speech) that results in either:

   - Persistent difficulty with perception, production, and/or representation of consonants, vowels, syllables, words, and/or prosody (tones, rhythm, stress, and intonation) that interferes with speech intelligibility and/or acceptability (33; 34; 35; 36).
   - Limitations in effective communication that interfere with social participation, academic achievement or occupational performance, individually or in any combination (33).

   (iii) Developmental language disorder, where the child or adolescent scores more than 1.5 standard deviations below the mean on a standardised language assessment.

   - Note: Further consultation will be needed to determine which language assessment to use. Options include the Pre-school Language Scale, Fifth Edition (37) and the Clinical Evaluation of Language Fundamentals (38), used in conjunction with functional impact reports.

   and

c. particularly for younger children, developing a list of concerns or "red flags" for GPs to use to help identify when children who may have these conditions should be referred for assessment.

Rationale 10

This recommendation focuses on ensuring that the MBS provides equitable access to assessment and treatment services for children with disabilities. It is based on the following:

- Evidence shows that allied health interventions improve outcomes for children with the following conditions:
    - **Stuttering.** Stuttering is a severe communication disorder that can worsen with age and become permanent if untreated. Early intervention is the most effective and efficient intervention. The Lidcombe program, delivered by a qualified speech pathologist, is the gold standard treatment for stuttering in children (39). A meta-analysis (*n* = 136) of Lidcombe program clinical trials and short exposure experiments showed an odds ratio of 7.7 for recovery from stuttering for those exposed to the program (40).
    - **Developmental language disorder.** A Cochrane meta-analysis found that speech and language therapy appeared effective for children with phonological or vocabulary difficulties (but less effective for children with receptive difficulties) (41). Other research supports the effectiveness of speech and language therapy (42).
    - **Speech Sound Disorder (SSD) (includes phonology and childhood apraxia of speech).** Speech and language interventions, as provided by speech pathologists, have been shown to be effective in improving clinical outcomes in children with phonological difficulties (28). Research into the most effective therapies for childhood apraxia of speech has expanded during the last five years. Murray et al. recommend that clinicians use a variety of treatment methods to improve outcomes (43). Qualified speech pathologists deliver these treatments.
- The AHRG agreed, based on clinical experience, that this patient cohort does not have adequate access to allied health services through chronic disease management plans and TCAs because they are not often considered to have a "chronic condition". These conditions are not always eligible for support under the NDIS (based on clinical experience engaging with families with speech, language or stuttering conditions).
- Adding children with the above conditions to the list of eligible disabilities under the MBS would improve access to services through access to associated Schedule fees.
- The AHRG agreed that any conditions added to the list of eligible disabilities under the MBS should be comparable to existing conditions on the list in terms of impact on quality of life.

AHRG Recommendation 10 – Endorsed for Government consideration

The Taskforce supports this recommendation and the AHRG's rationale.

Recommendation 11 – Improve access to the ASD and eligible disability assessment to people under 25

The AHRG recommends:

a. increasing the age limits on the following items:

    (i) 82000, 82005, 82010 and 82030 – from 13 to 25 years old,

(ii) 82015, 82020, 82025 and 82035 – from 15 to 25 years old,

and

b. changing the relevant item descriptors to say "a child or young adult" instead of "child".

Rationale 11

This recommendation focuses on ensuring that the MBS provides access to high-quality health services for young adults with ASD and/or eligible disabilities. It is based on the following:

- ASD is increasingly being diagnosed between the ages of 13 and 25, particularly in people with mental health illnesses, and in parents who may have undiagnosed ASD and may seek a diagnosis for themselves after their child has been diagnosed.
- There is a need to support young adults with ASD and disabilities as they go through important transitions, such as secondary to tertiary education, and education to employment and to address evolving physical and mental health issues associated with moving into adulthood.
- Research has indicated that formal transition plans are often missing for tertiary students with ASD. Many students feel the need for extra support, and comorbid anxiety, depression and executive function difficulties are major contributors to student difficulties (44).
- National guidelines for ASD assessment (as highlighted in Recommendation 6) specify that allied health professionals should be involved in making an ASD diagnosis (45).
- For patients over the age of 13 with a potential ASD diagnosis, there is no Schedule fee available for allied health assessment services. Patients require a diagnosis to access allied health services through Helping Children (people) with Autism Plans/M10 items. If patients over 13 who require assessment for ASD and/or eligible disabilities cannot pay out of pocket for allied health assessment services, they may remain undiagnosed and without treatment.
- Extending current M10 items for ASD and CND to young adults under 25 years old would facilitate high-quality care for Australians presenting late with ASD.
- To ensure equitable access to services for patients with eligible disabilities, the recommended changes should apply to both ASD and eligible disabilities under the MBS.
- To ensure equitable access to treatment services for children and adolescents, the recommended increase in age to 25 should apply to both assessment and treatment sessions.
- The AHRG noted that assessment services are not provided under the NDIS and that the MBS would provide an important service to eligible adolescent and young adults requiring an ASD assessment.

AHRG Recommendation 11 – Endorsed for Government consideration

The Taskforce supports this recommendation and the AHRG's rationale.

Recommendation 12 – Improve allied health collaboration during assessments

The AHRG recommends:

a. allowing inter-disciplinary referral between allied health professionals during the assessment phase for eligible disabilities and ASD (items 82000, 82005, 82010 and 82030), and

b. referrals be permitted:

(i) Within the first group of four allied health assessment appointments under M10 items (i.e. the referral can come from an allied health professional for the second, third or final appointment of this envelope).

(ii) Within the second group of four allied health assessment appointments under M10 items (i.e. the referral can come from an allied health professional for the second, third or final appointment of this envelope), if Recommendation 7 of this report is implemented.

(iii) In consultation and agreement with, but without a physical attendance by, the original referring practitioner (i.e. via telephone call, secure messaging):

- For M10 items for ASD, the original referring practitioner is the referring paediatrician or psychiatrist.
- For M10 items for eligible disabilities, the original referring practitioner is the referring specialist, consultant physician or GP.

Rationale 12

This recommendation focuses on ensuring that patients with potential ASD and eligible disabilities have access to timely diagnosis. It is based on the following:

- Based on clinical experience, the AHRG agreed that there are instances where inter-disciplinary referral between allied health professionals facilitates a more timely diagnosis.
- For example, a paediatrician may refer a child (using M10 items) to a speech pathologist for diagnosis of ASD. Based on information collected when assessing the patient, the speech pathologist may identify that the patient needs to see another allied health professional to meet the diagnostic requirements of the national guidelines for ASD assessment (as highlighted in Recommendation 6). Under the current system, the patient must return to the paediatrician to get a referral for an assessment appointment with the second allied health professional in order to be rebated under the MBS. Wait lists for specialists are often long, and requiring a patient to return to the referring practitioner for an additional allied health referral can slow down the ASD assessment phase.
- Throughout its discussions on this recommendation, AHRG members who assess patients with potential ASD reported that inter-disciplinary referral between allied health professionals already occurs, but there are no Schedule fees for M10 items. Instead, patients who are referred to an allied health professional by another allied health professional for assessment of ASD or an eligible disability must pay the full cost of the service out of pocket or through private health insurance.
- To ensure equitable access to services for patients with eligible disabilities, the recommended changes should apply to both ASD and eligible disabilities under the MBS.

AHRG Recommendation 12 – Endorsed for Government consideration

The Taskforce supports this recommendation and the AHRG's rationale.

The role of telehealth in allied health care

Recommendation 13 – Improve access to allied health services via telehealth

The AHRG recommends:

a. undertaking a follow-on piece of work detailing the highest-value opportunities for telehealth integration into allied health care, to gather national evidence, building on existing research on telehealth interventions conducted at the state and territory level and in federally funded trials and to identify:

   (i) Telehealth interventions provided by allied health professionals with evidence for comparable or superior clinical outcomes (compared with face-to-face interventions).

   (ii) Cost savings associated with using telehealth in allied health care.

   (iii) The views of consumers and feedback on telehealth use in allied health care.

   (iv) Exploring the use of telehealth interventions to complement existing models of care, especially for rural and remote areas.

b. in the interim, creating a new MBS item for the provision of telehealth services for patients consulting with an allied health professional via teleconference, with the following restrictions:

   (i) The patient must not be an admitted patient.

   (ii) The patient must be located both within a telehealth-eligible area and at least 15 kilometres from the allied health practitioner.

   (iii) The patient must reside in a rural or remote region (defined as Modified Monash Regions 4 to 7).

   (iv) The allied health professional must be a primary health care provider for the patient, defined as having had at least two consultations with the patient.

   and

c. that the new item should only be claimable for types of allied health professionals who can deliver comparable outcomes via teleconference as in face-to-face consultations to ensure that there is no compromise in service delivery or standard of care.

Rationale 13

This recommendation focuses on improving access to effective telehealth services. It is based on the following:

- The AHRG acknowledged that telehealth could be used to improve delivery of allied health care for rural and remote populations. However, it also noted that the current fee-for-service system under the MBS does not always create the right incentives for telehealth.
- There are 382 allied health professionals per 100,000 people in metropolitan areas, compared to just 136 in remote/very remote areas (46). In rural and remote areas, one in five patients report that they experience longer-than-acceptable waits to access health services (47).
- The AHRG agreed that this recommendation has the following benefits:
  - It would increase allied health service provision in remote, regional and rural areas. This would decrease the need for patients in rural and remote communities to travel (and take time off work) to receive allied health care.
  - For providers already providing telehealth services, the recommendation would reduce out-of-pocket fees by allowing rebates for patients. This would relieve the financial burden on patients who already face the hardships of distance, limited service provision and inequitable access to services.

- The recommendation would increase local employment by creating opportunities for locally based allied health assistants (who may provide patient-side support).

- There is some evidence to support telehealth interventions in allied health care. A recent Australian review of allied health video consultation services found that clinical outcomes have generally been similar to outcomes for usual care, although it acknowledged large differences in the breadth and quality of evidence between different allied health professionals (48).

- There is evidence that telephone counselling by a dietitian achieves dietary behaviour change and improves metabolic parameters in individuals with metabolic syndrome. Swanepoel and Hall (2010) conducted a systematic review of telehealth applications in audiology and found that outcome measures for conventional face-to-face services and remote telehealth services were similar, with no negative impact on patients who received telehealth services. Various types of audiological assessment were found to be viable, such as otoscopy, pure-tone audiometry, immitance audiometry, otoacoustic emission, and auditory brainstem response audiometry, with no clinically significant differences in results compared to face-to-face administration of these assessments (49).

AHRG Recommendation 13 – Referred

This recommendation was referred to the Telehealth Working Group.

Non-dispensing pharmacists

Recommendation 14 – Allow non-dispensing pharmacists to access allied health items

The AHRG recommends adding an item to allow pharmacists to provide medication management services to patients with complex care requirements outside of usual retail pharmacy operations as part of TCAs under M3 MBS items (up to twice a year).

Rationale 14

This recommendation focuses on improving access to medication education and management. It is based on the following:

- Pharmacists are not included in the individual allied health services (items 10950–10970) for chronic disease management items.

- An estimated 230,000 medication-related hospital admissions occur each year, with an estimated annual cost of $1.2 billion (50). These admissions are potentially avoidable.

- Pharmacy-led medication reconciliation interventions were found to be an effective strategy to reduce medication discrepancies (51).

- Consultations undertaken by pharmacists located within primary health care clinics have been shown to be effective in identifying and resolving medication-related problems in patients with complex care requirements (52; 53).

- Several submissions to the MBS Review supported funding for pharmacists to deliver medication management services as a way of improving health outcomes and reducing medication-related hospitalisations. This included submissions from the NT Government, the Pharmaceutical Society of Australia (PSA) and the Australian Healthcare and Hospitals Association.

- The AMA and the PSA has released a proposal to make non-dispensing pharmacists a key part of the future general practice health care team allowing potential of savings of public funds and avoidable hospitalisations (54).

AHRG Recommendation 14 – Not endorsed for Government consideration

The Taskforce acknowledges the value of non-dispensing pharmacists, but notes there are existing arrangements for Non-Dispensing Pharmacists to undertake medication reviews under the Community Pharmacy Agreement.

The Taskforce also notes significant policy changes impacting existing policy, such as the Community Pharmacy Agreement, have not been considered.

Longer-term recommendations

An allied health research base

Recommendation 15 – Support the codifying of allied health research and evidence

The AHRG recommends:

a. building an allied health research base, and

b. investing in allied health research—potentially funded by the Medical Research Future Fund (MRFF)—in the following ways.

(i) Collect and publish data on allied health usage patterns across all funding streams in one place. This data should provide transparency on which patients use which allied health interventions and should be publicly available. Information on both the therapy delivered and the outcome measures should be collected and included to build a robust data set for future research.

(ii) Identify priority areas for research, based on gaps in current research and burden of disease in the community. The AHRG noted the following topics as high priorities.

- Effective strategies for establishing behaviour change and self-management, as well as validated tools to measure this.
- Effective multidisciplinary/integrated care approaches to chronic disease management and primary prevention.
- Interventions to address the burden of chronic disease in Australia and health inequities (for example, among Aboriginal and/or Torres Strait Islander peoples, rural and remote communities, people with low socio-economic status).
- Long-term outcomes for patients with chronic disease receiving allied health interventions.
- The frequency and intensity (“dose”) of allied health appointments that improve outcomes for patients.
- The cost-effectiveness profiles of different allied health interventions.

(iii) Collate available, high-quality evidence for allied health interventions into an easy-to-use guide for allied health and other health professionals.

Rationale 15

This recommendation focuses on ensuring impactful investment into allied health research. It is based on the following:

- The AHRG identified three main issues with current allied health research:
    - Data collection and collation on allied health usage patterns across state, federal, private health insurance and privately funded allied health services is inadequate. For example, an Australian Bureau of Statistics survey revealed a 38 per cent average increase in services for 10 allied health professions between 2011-12 and 2014-15. It is not known why the Australian population is using more services (55).
    - High-quality evidence on the effectiveness of some allied health interventions is limited.
    - Available evidence has not been adequately translated into easy-to-use guidelines for health care professionals (including non-allied-health professionals, such as GPs).
        - Investing in evidence-based allied health interventions would facilitate the provision of cost-effective, high-quality care to Australians. The AHRG agreed that the proposals outlined in Recommendation 13 could identify the best ways to target allied health interventions to provide cost-effective, high-value care.
- The AHRG noted the following specific issues regarding a lack of effective strategies to increase patient compliance:
    - Non-compliance with home exercises in musculoskeletal cohorts can be between 30 per cent and 50 per cent. This places an additional burden on patients and health care providers and may be partially to blame for poor clinical outcomes. Strong exercise adherence is linked to improved treatment outcomes in patients experiencing neck and back pain and osteoarthritis symptoms.
    - It is widely accepted that there is no gold standard for measuring adherence to unsupervised home-based exercise at present. A significant proportion of outcome measures used in the literature rely on patient self-report and are therefore susceptible to bias.
    - Good adherence requires an individual to change, alter or even maintain a behaviour. Reasons affecting adherence rates include perceived barriers such as a lack of time, work commitments, the patient's own beliefs or their self-efficacy regarding the exercise task. For patients with chronic pain, compliance will also decrease if the home exercise increases their pain. Improved tracking of patients' coping strategies, pain and difficulties with home-based exercise should improve rehabilitation outcomes.
        - Biomedical research tends to dominate Australian health research, but it is not always the most cost-effective way to improve outcomes for patients (56). The AHRG agreed that this recommendation would provide an opportunity for the MRFF to invest in practical, policy-level research in allied health.

AHRG Recommendation 15 – Endorsed for Government consideration

The Taskforce support this recommendation and the AHRG's rationale.

Non-fee-for-service allied health payment models

Recommendation 16 - Pilot non-fee-for-service allied health payment models

The AHRG recommends:

a. undertaking a piece of work to understand how bundled and other non-fee-for-service remuneration models could help to better integrate allied health into the Australian primary health care system, to include the following:

   (i) Undertaking a cost-effectiveness analysis on the benefit of better integrating allied health into Australian primary health care.

   (ii) Reviewing patient groups, diseases and conditions that would benefit most from such integration.

   (iii) Designing and detailing remuneration models that would help to improve integration of allied health into the health care system.

   (iv) Monitoring patient outcomes from increased allied health intervention.

   (v) Determining a pilot approach for implementation of these findings.

   and

b. any pilot of a non-fee-for-service system for allied health care in Australia should preserve the autonomy of allied health professionals and should be voluntary for patients.

Rationale 16

This recommendation focuses on incentivising high value care. It is based on the following:

- The MBS fee-for-service system does not always provide the right incentives for high-value care.
- The fee-for-service system may not always improve patient outcomes via allied health care in the most timely or cost-effective way.
- There is some evidence that allied health improves patient outcomes and is cost-effective for the health care system.
    - A research project could identify the most efficient and effective models to maximise the potential benefits of allied health care.

AHRG Recommendation 16 – Endorsed for Government consideration

The Taskforce support this recommendation and the AHRG's rationale.

Communication between patients, allied health professionals and GPs

Recommendation 17 – Enhance communication between patients, allied health professionals and GPs

The AHRG recommends:

a. investing in a chronic disease management pathway education campaign for allied health professionals and GPs (especially if the MBS Review results in significant changes). This should promote shared

decision-making, which integrates a patient's values and care goals with the best available clinical evidence in order to make treatment decisions

b. improving communication between allied health professionals and GPs by:

   (i) Providing financial support for GPs and private allied health professionals to set up secure messaging systems. This would enable fast, confidential communication.

   (ii) Promoting more formal referrals between GPs and allied health professionals. Referrals under chronic disease management plans should take the form of a referral letter, similar to a referral to any other medical specialist (although these could still be sent virtually via a secure system).

   (iii) Ensuring, where possible, that all referrals and communication are uploaded to My Health Record (for patients who have not opted out). This should include information on the number of used and available allied health appointments under a patient's chronic disease management plan. This will allow allied health professionals and GPs to accurately inform patients about their care and likely associated costs.

   and

c. streamlining referrals from one allied health professional to another, in consultation with a GP. The above methods for enhancing communication between practitioners could foster faster communication when referral to another allied health professional may be appropriate.

Rationale 17

This recommendation focuses on simplifying and streamlining communication between allied health professionals, GPs and consumers. It is based on the following:

- The AHRG identified several issues relating to communication between GPs, patients and allied health professionals.
- Consumers are often unaware of the number of rebated appointments that are available for allied health MBS items throughout their treatment, and that there is likely to be a gap payment. This can be due to a lack of information for consumers, leading to an assumption that the service will be free.
- Consumers are often unaware of why they have been referred to an allied health professional.
- Standardised chronic disease management item forms lack scope for referral details, which means that allied health professionals have limited information to inform their treatment. This sometimes results in consumers needing to return to the referring practitioner, which is time-consuming, delays treatment and is less efficient.
- Inflexible communication methods between allied health professionals and GPs (often telephone is the only option) limits allied health professionals' ability to clarify components of a patient's care plan.
- Although software for secure communications is available, allied health professionals often cannot afford to invest in it.
- Consumers will benefit from the above recommendation because it will increase transparency in their care and improve the efficiency of chronic disease management care pathways. The AHRG noted, as an example, the work done by the Brisbane South PHN in improving communication between providers for chronic disease management.

AHRG Recommendation 17 – Endorsed for Government consideration

The Taskforce support this recommendation and the AHRG's rationale.

The role of allied health in the Australian public health care system

Recommendation 18 - Expand the role of allied health in the Australian public health care system

The AHRG recommends:

a. facilitating equitable access to clinically appropriate allied health services for individuals with identifiable risk factors for chronic disease in order to prevent the occurrence, or delay the onset, of chronic conditions (primary prevention) and recommends that this could be achieved in the following ways:

   (i) Through the MBS:

   - Enable MBS-funded allied health services to be accessed through health assessment items.
   - Create a GP Primary Prevention Plan (GPPP) to provide access to evidence-based allied health interventions for people with identifiable risk factors who do not meet the criteria for a GPMP—for example, individuals with pre-diabetes, hypertension, hypercholesterolemia or high body mass index (Body Mass Index (BMI); overweight/obesity).

   (ii) Outside the MBS:

   - Expand publicly funded, community-based allied health group interventions aimed at lifestyle modification, potentially through state and territory funding.

   and

b. eligible risk factors should include those with high prevalence and a large impact on health status such as those identified in the 2011 Australian Burden of Disease Study (57), including:

   (i) Tobacco use (accounting for 9.0 per cent of the total burden).

   (ii) High BMI, related to overweight and obesity (7.0 per cent of the total burden, based on enhanced analysis by the Australian Institute of Health and Welfare published in 2017, which used updated evidence of diseases associated with overweight and obesity and enhanced modelling techniques).

   (iii) Alcohol use (5.1 per cent of the total burden).

   (iv) Physical inactivity (5.0 per cent of the total burden).

   (v) High blood pressure (4.9 per cent of the total burden).

Rationale 18

This recommendation focuses on enhancing the complimentary role of allied health across the health system. It is based on the following:

- Allied health services are not leveraged enough to help Australia reach its strategic objectives for chronic disease. These objectives can be broken down into three desirable outcomes (58):
  - Reduce the proportion of Australians living with preventable chronic conditions or associated risk factors.

- Meet the voluntary global targets outlined in the WHO's Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020 (59).
- Provide timely interventions to Australians with chronic conditions or associated risk factors to achieve optimal health outcomes.

- Currently, the MBS and state and territory government services are the primary avenues through which patients with chronic disease can access publicly funded community-based allied health services. The MBS does not enable equitable access to lifestyle modification interventions and primary prevention facilitated by allied health professionals for people with identifiable risk factors of chronic disease.
- Investing in preventive health care offers the opportunity to improve clinical outcomes, reduce the burden of disease in the community and deliver cost savings to the Australian health system.
- A report commissioned by the Australian National Preventive Health Agency (2012), titled The Role of Australian Primary Health Care in the Prevention of Chronic Disease, supported referral programs to reduce risk factors for chronic disease, including those delivered by allied health professionals (60). This review noted the following:
  - There is increasing evidence that brief interventions in general practice—especially for diet, physical activity, weight and multiple risk factors of chronic disease—are important and valuable, but insufficient to achieve and maintain behaviours and physiological changes.
  - Referral programs need to be of sufficient intensity (usually at least six sessions over several months) to be effective and sustainable.
  - Referral programs should be integrated into primary health care, with primary health care providers involved in initial assessment and long-term follow-up.
  - Maintenance of behaviour change is the major goal of long-term monitoring and support.
- There is evidence to support the efficacy of allied health interventions in reducing risk factors for and progression to chronic disease, including:
  - **Impaired glucose tolerance (pre-diabetes):** Exercise has been shown to improve blood glucose control, reduce cardiovascular risk factors, contribute to weight loss and improve well-being in patients with pre-diabetes (61). Improvements in diet and physical activity have specifically been shown to delay the incidence of type 2 diabetes in people with impaired glucose tolerance (pre-diabetes) (62). Other studies have shown that these interventions are also cost-effective. For example, a systematic review identified median incremental cost-effectiveness returns for diet and physical activity promotion programs of $13,761 per quality adjusted life year (QALY) saved. For people with pre-diabetes, delivery of an exercise intervention by an accredited exercise physiologist brings expected annual savings in health system expenditure of $1,977 per person (63).
  - **Hypertension:** Lifestyle modification, including increased physical activity and dietary changes, is considered a first-line treatment for patients with low-risk profiles aiming to reduce blood pressure while concurrently reducing the risk of cardiovascular events (63). The Activity, Diet and Blood Pressure Trial's (ADAPT) 16-week lifestyle modification program promotes:
    - weight loss,
    - a low-sodium diet that high in fruit, vegetables and fish,
    - increased physical activity, and
    - reduced alcohol intake.

It has been shown to lead to short- and medium-term benefits, with the potential for long-term reduction of cardiovascular risk in patients treated for hypertension (64). It is recognised that allied health professionals (for example, exercise physiologists, physiotherapists, dietitians) play an important role in the management of patients with hypertension by influencing and reinforcing appropriate lifestyle behaviours to achieve blood pressure control (65; 66).

AHRG Recommendation 18 – Objective supported but referral to relevant research initiatives recommended

The Taskforce supports this recommendation in principle, but agrees that expansion is a longer-term consideration which will be informed by broader directions in primary care and evidence gathering through robust research.

4.4.4 Allied Health Reference Group Stakeholder Impact Statement

Both consumers and allied health professionals are expected to benefit from the recommendations in this report. In making its recommendations, the AHRG's primary focus was ensuring consumer access to high-quality allied health services. The AHRG also considered each recommendation's impact on allied health professionals to ensure that it was fair and reasonable.

Consumers will benefit from the AHRG's recommendations through improved access to higher quality allied health services that complement primary care stewardship, particularly in chronic disease management, complex neurodevelopmental disorder management and high-quality group therapy.

- **Improved access to allied health services:** The AHRG has recommended to expand the number of MBS-funded allied health consultations for patients who have complex and chronic conditions. The AHRG's recommendation for expanding the number of MBS-funded consultations for patients with chronic conditions would help ensure that the best preventive and treatment outcomes are provided. The AHRG's recommendation for new orthotic and prosthetic items would support timely and appropriate preparation and education for patients when given their prosthesis. Increasing the number of appointments for children being assessed for ASD or other eligible disabilities would help these patients to be correctly diagnosed and assessed by the appropriate range of allied health professionals. Including severe speech and language disorders in the M10 would recognise the impact of speech and language disabilities in the community, and provide an appropriate avenue for treatment. Improving allied health access to telehealth would promote timely allied health advice and follow up for patients in rural and remote regions.

- **Removing inefficiencies and barriers to care:** The AHRG has recommended that available allied health services be expanded where they are integral to effective, holistic care. Allowing allied health services to be accessed through GP-led primary prevention plans would help patients with risk factors and chronic conditions receive appropriate allied health services early. Longer assessment consultations would ensure that patients with complex or chronic conditions are provided with a comprehensive assessment and follow up care. Broadening assessment items to allow more appropriate allied health professionals to be involved in the diagnosis and case management of patients would expand patients' access to the most comprehensive healthcare available. Extending disability assessment and treatments for ASD and eligible disabilities to persons under the age of 25 would promote continuous support for young adults through important life transitions. Allowing practitioners to communicate with each other through case conferencing would support timely, appropriate care.

- **Improved patient access to high quality group therapies:** The AHRG has recommended that group therapies be incentivised and expanded. Allowing M10 treatment items to be delivered as group therapy would help realise the social and support benefits of groups, particularly for children and

carers. Increasing the schedule fee for certain group therapies would also improve the viability of these high-quality interventions as a business model.

Allied health professionals would benefit from the AHRG's recommendations through a more accurate representation of their scope of practice being reflected in the MBS, and through the increased financial recognition of the care they provide. Allied health professionals, more broadly, would benefit from the AHRG's recommendations by having increased choice in working models as allied healthcare becomes a financially and structurally viable option.

Consumers, allied health professionals and the Australian health care system would benefit from overall increased investment in allied health, particularly in allied health research and future models of allied health financing. These benefits would accrue from high-quality, cost-effective prevention and treatment outcomes that benefit patients and the community both now and into the future.

4.5 Mental Health Reference Group

4.5.1 Mental Health Reference Group's Areas of Responsibility

A list of all items reviewed by the MHRG can be found at Appendix B.

The MHRG reviewed 47 MBS items:

- three group therapy items (A6),
- four pregnancy support counselling items (A27 and M8),
- ten general practice mental health treatment items (A20),
- five psychological therapy services items (M6),
- 15 FPT items (M7),
- two allied health services items (M3), and
- eight autism, pervasive developmental disorder and disability services items (M10).

The M3 and M10 items are also being reviewed by the AHRG. One M3 item is also being reviewed by the Aboriginal and Torres Strait Islander Health Reference Group.

The 47 mental health items primarily cover Mental Health Treatment Plans (MHTPs) and associated psychological treatment strategies. In 2016/17, these items accounted for approximately 8.8 million services and $834 million in MBS benefits. Over the past five years, service volumes for these items have grown at 9.4 per cent per year, compounded annually (CAGR). The cost of benefits per service has increased by 0.3 per cent per year (CAGR) (Figure 18).

In 2016/17, the items for "Attendance for focussed psychological strategies services by psychologist" and "Assessment and therapy by clinical psychologist lasting at least 50 minutes" accounted for approximately 52 per cent of service volume (28 per cent and 24 per cent, respectively) (Figure 19).

Figure 18: MHRG – Drivers of benefit growth for in-scope items

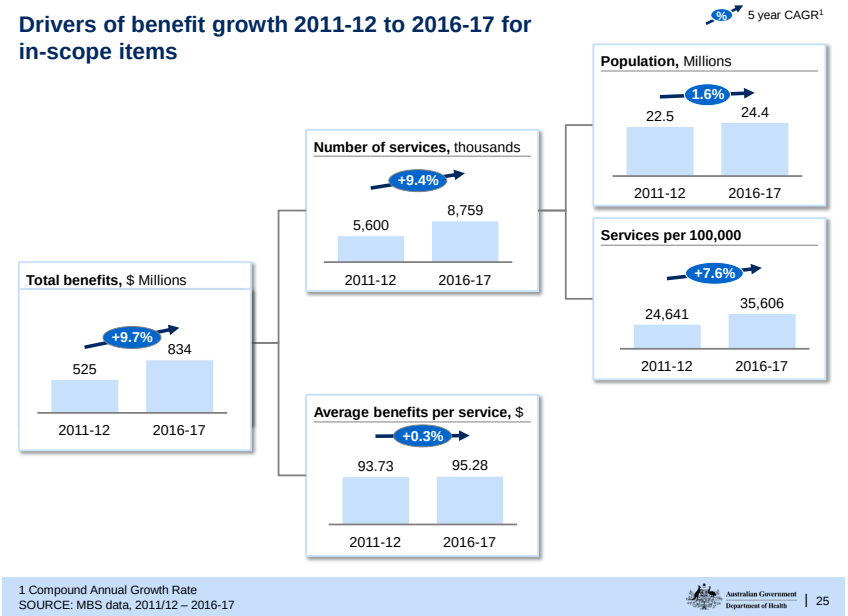
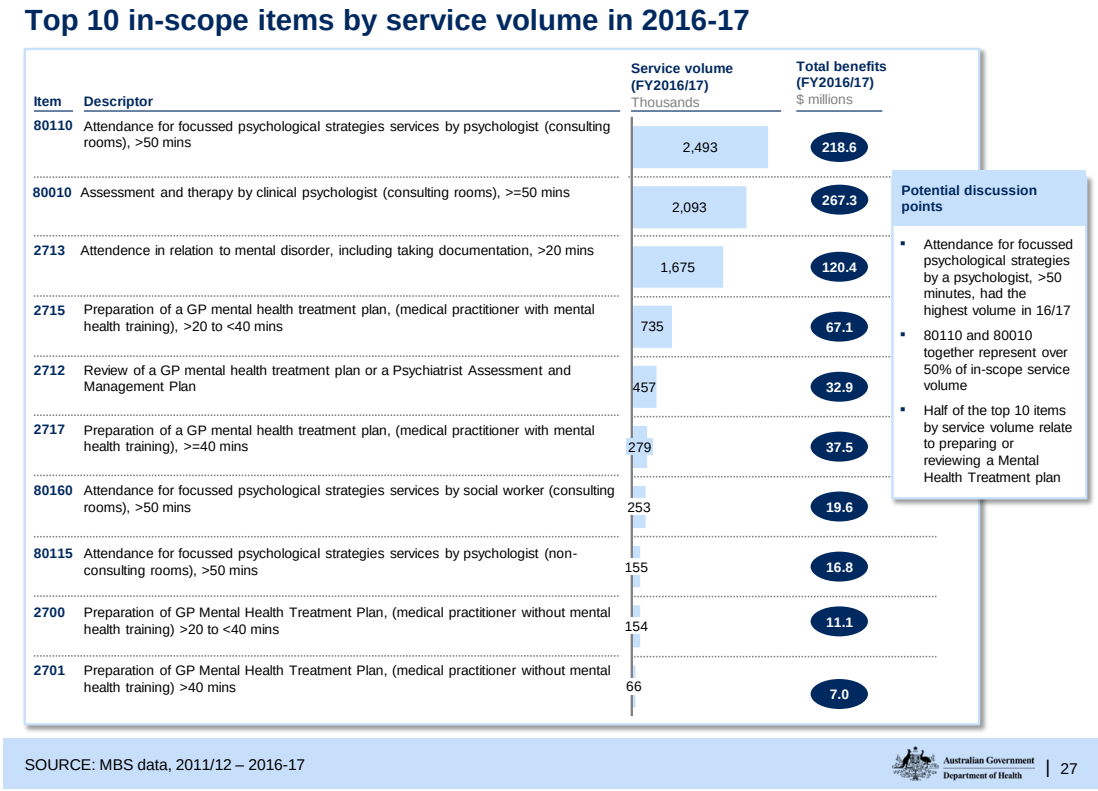


Figure 19: MHRG – Mental health items (ordered by service volume)



4.5.2 Mental Health Reference Group's Review Approach

The MHRG completed a review of its items across four full meetings, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including data on:

- utilisation of items (services, benefits, patients and growth rates),
- service provision (type of provider, geography of service provision),
- patients (services per patient), and
- additional provider and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through medical journals and other sources, such as professional societies.

The MHRG considered relevant stakeholder submissions to the MBS Review in making its recommendations.

Main Themes

The MHRG's recommendations were guided by four overarching themes:

1. Apply a stepped care approach to MBS mental health services (Recommendations 1, 3, 10 and 12).
2. Increase the flexibility of MBS mental health services (Recommendations 2, 5, 6, 13, and 14).

3. Incorporate the latest evidence into the MBS approach to mental health services (Recommendations 7, 8, 9 and 11).
4. Address ongoing questions in the mental health provider community (Recommendation 4).

Consumer impact

The MHRG developed recommendations that are consistent with the Taskforce's objectives and focus on improving access and value for consumers through the delivery of appropriate mental health care. MHRG members discussed a range of issues in the mental health space, considering challenges in consumer access, flexibility, outcomes and collaboration in a multidisciplinary care setting.

The MHRG's recommendations are intended to enable the following.

- **Access and flexibility:** Changes to MHTPs will make them available to those at risk of developing a mental disorder, providing a platform for prevention and early diagnosis and treatment. This means that appropriate services will be available for consumers earlier in their treatment pathways. Other recommendations promote access to care in group settings, via telehealth and in aged care settings.
- **Stepped care triage:** Recommendation 3 will strengthen the Better Access items by creating a triaged structure. This will allow consumers to access the level of intervention that is right for them, and will ensure that treatment can be appropriately informed and planned. This will provide a broader range of services suited to individual needs, targeting people whose needs are more complex. Other recommendations enhance this format by updating the treatment options for mental health service delivery under Better Access, and by adding family and carer session options.
- **High-value care:** To ensure that the recommendations outlined in this report achieve the best possible outcomes, Recommendation 4 notes the additional work required to review access to the MBS for different professional groups and appropriate schedule fee for mental health services. Recommendation 2 enables flexibility in the referring clinician review structure, avoiding low-value reviews where unnecessary, while still allowing for high-value reviews and collaboration between providers. Other recommendations address interactions with other parts of the health system, such as acknowledging the physical health of those with mental illness (and vice versa) and the interaction between mental health services and the aged care sector.

Flexibility, access and choice in mental health services

The Government's response to *Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services* (1) recognised that services provided through the Better Access program have been the biggest drivers of advances in treatment rates since the program's inception in 2006. However, it also acknowledged that Better Access is a "one size fits all" program and may not be the most efficient pathway for everyone with a diagnosed mental health illness.

While the MBS is also a "one size fits all" program, the MHRG agreed that there is sufficient scope to tailor services for populations in need. This became a focus of the MHRG's recommendations. This theme is relevant not just to the recommendations contained in this report, but also to the current challenges and future directions of mental health care delivered through the MBS.

The MHRG identified the following issues:

- **Access and choice in service provision:** A common theme, evident across several submissions and embedded throughout numerous discussions within the MHRG, was the need to ensure that consumers have adequate access to mental health services through the MBS. The MHRG also highlighted the importance of consumer choice in mental health provision to promote a strong therapeutic alliance, noting that the commercial interests of health professionals should not influence

this choice. The MHRG noted that several submissions discussed the proximity and affordability of services, and the complexity of the referral process.

- **Stepped care models and equitable access to care:** The MHRG understands from many submissions that some patients are unable to access as much care as they need. At the same time, MBS data shows that many patients with an MHTP do not use all of the sessions to which they are entitled. The MHRG also noted the preventive value (both in health outcomes and economic terms) of access to rebated services for patients who do not have a current diagnosable mental illness but are at risk of developing one in the immediate to short term.

- These factors formed the backdrop of several conversations on stepped care models. Stepped care models are evidence-based staged care systems consisting of a hierarchy of interventions, from the least to the most intensive, matched to an individual's needs. These models increasingly drive approaches to mental health services in Australia (for example, in PHN services). The introduction of a comparable approach within Better Access would mean that a person presenting to the mental health system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest, least-intensive level of intervention in order to progress to the next "step", or tier. Instead, an appropriate service level is assigned according to clinical need when the individual enters the system, and the number of sessions can be adjusted as treatment proceeds.

- Discussion about mental health service provision through the MBS highlighted GPs' crucial role in the referral process, in collaboration with the consumer and service provider, as well as their role as mental health clinicians. This referral role is important within a stepped care model as GP stewardship can help guide patient access to the right level of care. Ongoing communication between the referring practitioner, the mental health service provider and the patient can ensure that the patient continues to navigate all health services effectively.

4.5.3 Mental Health Reference Group Recommendations

Key recommendations

The MHRG is recommending significant amendments to existing items, the creation of new items, and the development of a new working group or committee to resolve outstanding questions. All recommendations seek to improve access to mental health services for Australians, taking into consideration the latest evidence and focusing on preventive, flexible and cost-efficient models of care.

The MHRG's recommendations are summarised below.

GP Mental Health Treatment Plans

1. Expand the Better Access program to at-risk people
2. Increase the maximum number of sessions per referral

Better Access items

3. Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness
4. Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups
5. Reduce the minimum number of participants in group sessions
6. Add a new group item for therapy in larger groups

Longer term recommendations

Recommendations that are longer term are listed below:

7. Enable family and carers to access therapy and/or consultation
8. Measure Better Access outcomes
9. Update treatment options
10. Unlink GP focused psychological strategy items from M6 and M7 items
11. Encourage coordinated support for patients with chronic illness and patients with mental illness
12. Promote the awareness of digital mental health and other low-intensity treatment options
13. Support access to mental health services in residential aged care
14. Increase access to telehealth services

Below are the recommendations from the MHRG's report. The recommendations are intended to improve access to mental health services focussing on preventative, flexible and cost-efficient models of care.

Mental Health Treatment Plans

Recommendation 1 – Expand the Better Access Program to at-risk people

The MHRG recommends expanding the Better Access program to at-risk people (items 2700, 2701, 2715 and 2717):

a. by amending the explanatory note (AN.0.56) to:

   (i) Include people who are considered at risk of developing a mental health disorder in the next 12 months in the section on eligibility for an MHTP,

   (ii) replace the words "structured approach" with "planned approach", and

   (iii) include in the definition of "at risk" both early presentations with no previous history and those who are currently relatively symptom free but require professional service for relapse prevention.

   and

b. amending the explanatory note as follows:

Revision to Explanatory Note AN.0.56 – example text

What people are eligible - Mental Disorder

These items are for people with a mental disorder, or at risk of a mental disorder, who would benefit from a planned approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional, behavioural, and/or social abilities (Refer to the WHO, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Those at risk of mental disorder are either

a) those with early, sub-syndromal symptoms of the disorders referenced above, who have a high likelihood of developing such a disorder in the next 12 months without timely and appropriate treatment, or

b) those who have recovered from a previously diagnosed disorder as referenced above and require treatment to maintain their mental health and prevent relapse.

Dementia, delirium, tobacco use disorder and intellectual disability on their own are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

Notes:

1. The MHRG noted that the 11th revision of the International Classification of Diseases (ICD-11) was published in June 2018 and expects item descriptors to be amended accordingly when this comes into force in January 2022.
2. The MHRG also noted that this recommendation could interact with Recommendation 2 and Recommendation 3. Its expectation is that patients with an MHTP who are deemed part of the at-risk cohort will access a maximum of 10 Better Access sessions per 12-month period, with the referring provider making the initial referral for the maximum 10 sessions.

Rationale 1

This recommendation focuses on making MHTPs more widely available to those who would derive high value from access to mental health services but are currently not able to access these services. It is based on the following:

- This recommendation would align eligibility for MBS-subsidised mental health care with requirements introduced for PHNs as part of recent Commonwealth mental health reforms (1). PHNs are mandated to commission services for individuals at risk who present with early symptoms, and to ensure that early interventions are targeted at hard-to-reach groups who face obstacles in accessing MBS services.
- There is significant health value in preventing deterioration in mental health for those who experience early, sub-diagnostic symptoms, and for those who have recovered from a previous mental health disorder but remain at risk of relapse without adequate maintenance care, due to their heightened vulnerability.
- People who receive early treatment for potential mental health disorders need continued support to consolidate therapeutic gains. They remain vulnerable to relapse when conflicts arise, they are affected by comorbidities and/or previous behavioural patterns re-emerge. Use of relapse prevention strategies is inherent in treatment protocols across mental health.
- Access to mental health care for this population would reduce pressure on other MBS services, as well as potentially reducing costs for other health services. The MHRG acknowledged that reduced costs may be seen across other budgets (for example, social welfare) as well as within health services, but these are harder to track and/or quantify. However, the MHRG noted the following potential efficiencies resulting from this recommendation:
    - Within the MBS, this recommendation would reduce the total number of sessions used by some patients by addressing sub-syndromal symptoms earlier, when they are easier to manage.
    - There are follow-on advantages to this across the health system, including:
        - Reduced admissions into emergency departments (2).

        - Reduced hospital presentations (by number and bed days). Examples include patients referred at subthreshold levels for panic disorder and early psychosis, and women in the perinatal period (3; 4).
    - Research conducted at the London School of Economics noted the substantial savings from investing in early intervention for young people in the United Kingdom, with "perhaps £15 in costs avoided for every £1 invested" (5).

- The MHRG also noted that people at risk of developing a mental disorder have limited alternative options for accessing care. While PHNs are now expected to commission services for those at risk of mental illness, PHN funding is limited and targeted at specific populations. For example, service eligibility is sometimes restricted to those with low incomes or health care card holders. Enabling access to care for the at-risk population through the MBS would ensure consistency and reliable access across communities.
- The role of public mental health services is to focus on the severe and acute end of the spectrum, and to provide access to treatment for people who require it under the provisions of the Mental Health Act for their respective jurisdiction (6).
- As the primary point of contact for other health concerns, GPs are well placed to assist in identifying and addressing risk factors for mental health, particularly for consumers who may otherwise not present to a mental health practitioner.
- Enabling access to care for the at-risk population without requiring a formal diagnosis could reduce stigma around mental health disorders, increasing the potential for healing without progression into full mental illness.

Members of the MHRG noted clinical experience with patients who expressed concern about a diagnosis being recorded on their file, which may feature in future medical checks in applications to the military, police force, etc.

MHRG Recommendation 1 – Not endorsed for Government consideration

The Taskforce agrees the Better Access Initiative should not be expanded at this time. Acknowledging the historical debate within the mental health provider community concerning Better Access MBS items, the Taskforce supports MHRG Recommendation 4 and recommends establishing a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups.

Recommendation 2 – Increase the maximum number of sessions per referral

The MHRG recommends increasing the number of sessions per referral (items 2700, 2701, 2715 and 2717), by:

a. by amending the explanatory note (AN.0.56) to:

   (i) increase the maximum number of sessions in any one referral from six to 10 sessions in the sections on "Preparation of a GP Mental Health Treatment Plan" and "Referrals",

   (ii) clearly state that 10 sessions is the maximum number of sessions from any one referral (rather than a minimum or required number of sessions), and that the referring practitioner should use their discretion in setting the referred number of sessions for any course of treatment, and

(iii) encourage discussion with the patient, as well as with the mental health provider, in determining the appropriate number of sessions for initial and subsequent referrals.

b. amending the explanatory note as follows:

Revision to Explanatory Note AN.0.56 – example text

In the section titled "Preparation of a GP Mental Health Treatment Plan":

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP. For the purposes of the Medicare rebateable mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of ten in any one referral). The number of services that the patient is being referred for is at the discretion of the referring practitioner (e.g. GP). The referring practitioner is encouraged to discuss the appropriate number of referred sessions for a single course of treatment with the referred practitioner providing the mental health services, as well as with the patient.

In the section titled "Referral":

When referring patients, GPs should provide similar information as per normal GP referral arrangements, and should include both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly nominating a specific number of sessions. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for a course of treatment (a maximum of ten services) but may be less depending on the referral and the patient's clinical need).

and

c. amending the explanatory note for the mental health provider (MN.7.1) to include:

(i) a requirement for return communication from the mental health provider to the referring provider (in this case, a GP),

(ii) that the mental health provider should communicate with the referring provider within the first four Better Access sessions, and

(iii) that this could include, for example, confirming that the MHTP has been actioned and that the patient has attended Better Access sessions, and/or an indication of the estimated number of sessions the patient will require for a full course of treatment.

Rationale 2

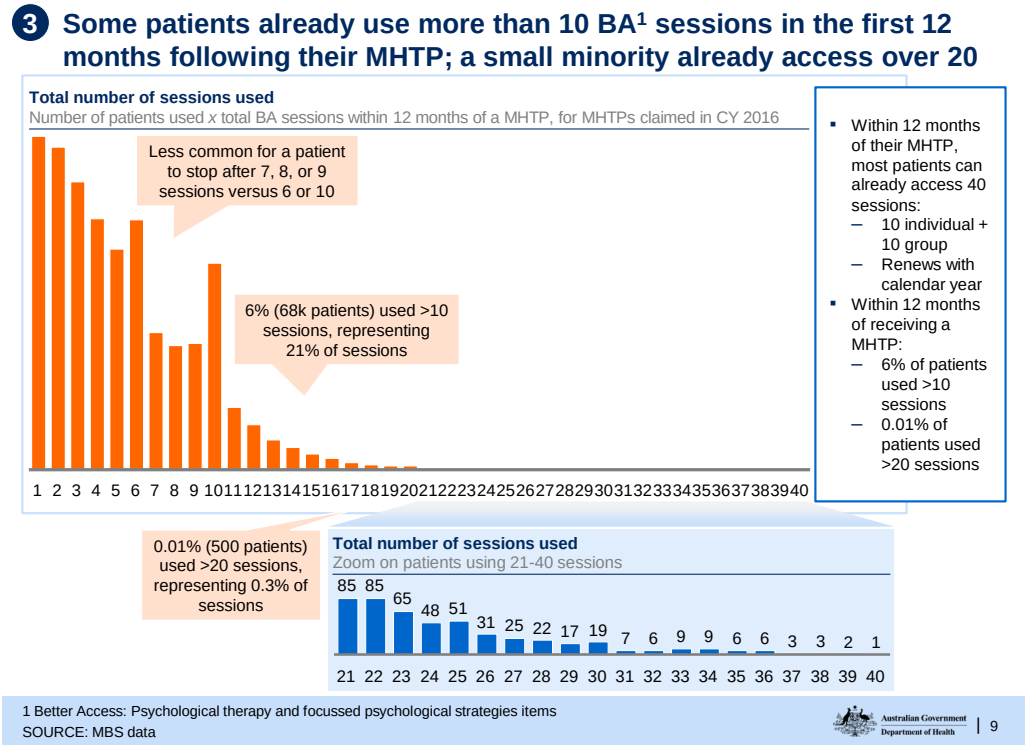
This recommendation focuses on improving access to mental health treatment sessions for patients who have an MHTP. It is based on the following:

- The MHRG agreed that enabling the provision of up to 10 sessions for the initial referral under an MHTP would simplify access to care for some patients:
    - Requiring the patient to return to the referring practitioner (generally a GP) after the sixth session creates a barrier to accessing further sessions if the patient does not follow up with their GP (Figure 20).

- Requiring the patient to return to the referring practitioner may also interrupt the therapeutic flow of a course of treatment if the patient has to wait several weeks to see their GP.
- The interruption to the course of treatment can be even more pronounced in rural areas, where access to the GP may be more infrequent.

- The MHRG agreed that this recommendation would not impede the ability of the referring practitioner to exercise clinical discretion in determining the right amount of care for each patient. The referring practitioner may refer for any number of sessions between one and 10, based on their clinical discretion.

Figure 20: MHRG – Difference in patients attending seven, eight or nine sessions, compared to six or 10 sessions



- The MHRG encourages more pro-active and timely follow-up between the referring practitioner and the provider of mental health services. While the MHRG expects follow up by the mental health provider, it noted that communication should be appropriate to the needs and complexity of the patient. The MHRG also believes that practitioners should establish the means and interval of coordination and communication that is most practical and relevant.
  - The MHRG noted that increased monitoring of outcomes may help to reduce risks of low communication between the GP and the mental health provider (although outcomes monitoring should not replace this communication).

- The MHRG agreed that this recommendation has the potential to reduce spending on unnecessary GP reviews. Currently, GPs are required to review a patient's progress under an MHTP after a maximum of six sessions. This review may take the form of a standard GP attendance, an MHTP review item or a GP mental health treatment attendance (item 2713).

- This review may not always be clinically necessary and may provide low-value care in situations where the referring practitioner has ongoing communication with the provider of mental health services, and/or knows that the patient will require further sessions without modification of the referral. Offering GPs the flexibility to request more sessions per referral allows them to avoid a review when it may not be clinically necessary.

- Recommendation 2 needs to be considered in the context of Recommendation 3 that proposes a 3-tiered approach to accessing Better Access sessions. Within this model, a patient could be referred for an additional two courses of treatment beyond the initial referral, with each course requiring a separate referral by the GP and movement between the tiers determined by defined clinical criteria. Recommendation 2 however should be considered on its own merits in the event that government does not accept Recommendation 3.

MHRG Recommendation 2 – Not endorsed for Government consideration

The Taskforce agrees a GP review is necessary, and that GP stewardship should be maintained to ensure a collaborative care approach.

Acknowledging the historical debate within the mental health provider community concerning Better Access MBS items, the Taskforce supports MHRG Recommendation 4 and recommends establishing a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups.

Better Access items

Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

The MHRG recommends:

a. introducing a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness,

b. changing the item 80000–80015, 80100–80115, 80125–80140 and 80150–80165 descriptors to specify that instead of 10 planned sessions in a calendar year, patients can access up to three tiers of Better Access sessions, with each tier allowing a greater number of sessions with:

   (i) each tier to provide access to a different maximum number of sessions within a 12-month period (for example, Tier 1 -10, Tier 2 – 20, Tier 3 - 40),

   (ii) access to, and progress through, the three tiers will depend on the severity of the patient's condition requiring treatment, defined by a number of factors outlined below, and

   (iii) a patient's access to each higher level tier would require GP review. Thus, a GP would need to endorse, by way of a review, a patient's need to progress from Tier 1 to Tier 2 at the completion of Tier 1, and from Tier 2 to Tier 3 at the completion of Tier 2. The intent is that the GP's central stewardship role be maintained in the proposed tiered Better Access system.

c. amending the item descriptors are as follows:

Revision to descriptors – example text

These therapies are limited, being deliverable in a maximum number of planned sessions in a 12-month period, all of which may be provided via video conference for patients living in telehealth-eligible areas (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). The maximum number of planned sessions before review will fall into one of three tiers and should be detailed by the referring practitioner at each transition between tiers.

and

d. consistent with Recommendation 1, a maximum of 10 sessions for the first tier and for higher tiers, a maximum of 20 sessions is recommended for the second tier and a maximum of 40 sessions for the third tier, within any 12-month period.

Note: The MHRG noted that session maximums falling below this level would significantly limit the effectiveness of the recommendation for a range of conditions.

a. to align with Recommendation 2:

(i) there may be two or more courses of treatment within a patient's entitlement of services per calendar year

(ii) the GP should consider the patient's clinical need for further sessions after the initial referral, and

(iii) using a GP MHTP Review, a GP Mental Health Treatment Consultation or a standard consultation item.

and

b. adding a new explanatory note to:

(i) provide guidance to the referring practitioner on assessing whether a patient should be referred for additional sessions,

(ii) shift the relevant time period from the current arbitrary calendar year to per 12-month period, where the 12 months commences from the date of the initial referral, and

(iii) detail the clinical criteria and thresholds to be met for the referral of patients from Tier 1 to higher levels, including:

- Criteria need to be based on, but not solely confined to, disorder type (diagnosis). Additional considerations in setting thresholds would include severity of symptoms, duration of mental health disorder (chronicity), impact of disorder on functioning, response to previous treatment (if applicable) and complexity (co-morbidity).
- Evidence of progress in therapy, the need for further therapy and the clinical rationale for ongoing treatment (comorbidities, additional trauma) should also be considered.
- The decision should emphasise evidence-based clinical need, collaboratively established with the referrer, mental health provider and consumer, rather than setting a number determined prescriptively.

Rationale 3

This recommendation focuses on increasing access to mental health services to appropriate levels for patients with moderate to severe mental health disorders. It is based on the following:

- The MHRG noted that patients with moderate to severe mental health disorders, a small cohort with the highest mental health illness burden, do not currently receive the treatment they need through the MBS.
- Eleven per cent of patients with an MHTP used 10 or more Better Access sessions in 2016, and 12 per cent used 10 or more in 2015. This usage pattern suggests that a subset of patients with an MHTP need additional support and are extending their usage of the Better Access sessions.
- Analysis by DoH showed that between 2006 and 2014, the one-third of patients who used 10 or more services in the four years following their first session accounted for 71 per cent of services. This group

included 5 per cent of patients who used 31 or more services and accounted for 21 per cent of services (7).

- Patient session allocation should be determined based on clinical need, rather than arbitrary session limits. Evidence demonstrates the need for more than 10 sessions for specific disorders.
- Under an earlier system, which enabled patients to access rebates for up to 18 sessions in exceptional circumstances, survey data showed that over one-third (37 per cent) of the subset of clients requiring more than 10 sessions required the full 18 sessions to achieve an effective clinical outcome. Another 37 per cent required 11 or 12 sessions to achieve effective outcomes (8).
- The MHRG agreed that these patients do not currently receive adequate care through other mechanisms, e.g.:
    - Access to mental health services under PHNs is limited by funding and eligibility rules. Eligibility for the stepped care model of PHN funding is often restricted to disadvantaged groups (for example, those from lower socioeconomic backgrounds). People who do not meet these conditions are therefore unable to access stepped care support beyond the current maximum number of MBS-rebated sessions.
    - The Mental Health Nurse Incentive Program (MHNIP) provided support in this area, but the program was discontinued in June 2018. While the MHRG is not aware of data collected on the impact of this change, clinical experience suggests that many MHNIP clients did not fully transition to PHN funding.
    - Public mental health services are focused on the most acute and severe presentations of low-prevalence mental illnesses. Those with chronic mental illness (who do not have a low-prevalence disorder or major mental health disorder), and particularly those with some functional capacity (i.e. still in employment), may have limited access to ongoing support from public mental health due to demand for services.
- The MHRG agreed that the MBS is an important avenue through which to support these patients.
- Private practice settings are the most able to provide continuous care with the same therapist in the context of an effective therapeutic alliance. In private practice, mental health professionals and referring GPs work collaboratively within the MBS framework. In this setting, a GP can identify a therapist who is most likely to be a “good fit” for each patient with chronic or severe mental illness, based on their knowledge of the patient’s needs and the therapist’s skill, experience and characteristics. The process is straightforward: a patient and/or GP can make direct contact with the treating clinician, and a collaborative approach to mental health care is more easily achieved.
- The short-lead funding cycle for PHNs affects staff quality and turnover and makes it difficult for the PHN system to consistently promise continuity of care.
- The MBS model enables more consumer choice and has fewer access limitations than services commissioned by PHNs (where patients and GPs are restricted to the staff of providers commissioned by the PHN).
- The MHRG agreed that appropriate treatment would result in optimal outcomes for these patients. With long-term care, this group of patients gets better over time. This reduces hospital admissions, reduces the use of other health services, and improves community and workforce engagement.
- The current model can result in arbitrary interruptions to treatment. For example, when a patient’s sessions “run out” for the year, they must wait for the next calendar year to continue treatment.

- The MHRG noted that this change could be cost-effective in the medium to long term. A small proportion of patients are repeat users of the MBS and drive most service volume. Adequate care (i.e. an appropriate dosage) in the first year would ensure that fewer patients return for frequent psychological services in following years.
- Some patients are referred to psychiatry sessions when their 10 sessions have run out, which is not cost-effective and is disruptive for the patient (the model of care is different under psychiatry, and the patient has to change their mental health provider). When these patients do not receive adequate treatment, costs increase for the rest of the health system—for example, through emergency department presentations and hospital admissions (9; 10).
- Under the MHNIP, providing flexible and unlimited contacts for clients
    - reduced emergency department presentations, hospitalisations and length of stay in hospital;
    - allowed for early discharge management; and
    - prevented relapse overall (11).
- Twenty-six per cent of emergency presentations and 25 per cent of inpatient admissions to mental health beds were for people with personality disorders, when measured over four years for one local health district in NSW (12).
- Appropriate treatment for these patients could also reduce the long-term cost burden on other major agency budgets, such as the social welfare system.
- The specific language of the explanatory note will require further consultation, research and expert input from professional bodies and relevant academic units. The MHRG discussed but did not arrive at a clear consensus on the different factors that would determine a patient's level of care, as outlined above, but noted that there is a significant body of research and evidence-based treatment protocols available to inform the development of the tier threshold criteria.
- The MHRG did not align different levels of care with different professions or qualifications. Some members of the MHRG, dissented from the part of the recommendation which states that the MHRG did not align different levels of care with different professions or qualifications. Instead, they noted that their understanding was that a new working group or committee would establish whether different levels of care should be associated with different professions or qualifications.
- The MHRG acknowledged that this recommendation may involve complex system changes for DHS.

MHRG Recommendation 3 – Objective supported but alternative (non MBS) mechanism recommended

While the Taskforce notes there may be evidence to suggest a gap in services, it is unclear there is sufficient evidence that simply increasing the number of sessions would address this need.

The Taskforce also notes that this recommendation is not well defined and the proposed model of care would be better placed outside the MBS.

Acknowledging the historical debate within the mental health provider community concerning Better Access MBS items, the Taskforce supports MHRG Recommendation 4 and recommends establishing a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups.

Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

The MHRG recommends establishing a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups, noting that:

a. the group would need adequate time and resources to complete its mandate,

b. government would need to carefully consider membership of the group to ensure unbiased, balanced and well-informed discussion and recommendations, and

c. this new group should be established urgently to maximise value for the patient and the health system.

Rationale 4

This recommendation focuses on resolving an outstanding debate within the mental health provider community, which concerns access to, and rebates for, different Better Access items for patients within the MBS. It is based on the following:

- Several different professions provide services focused on treating patients with mental health concerns under the MBS. With the aim of improving treatment and management of mental illness in the community, Better Access relies heavily on mental health professionals from a range of professional backgrounds to provide appropriate services to meet these needs.
- By design, there are a number of constraints attached to the MBS Better Access items related to the treating practitioner's type of training, accreditation and registration. For example, social workers must be a member of the Australian Association of Social Workers (AASW) and certified as meeting the relevant standards.
- items are currently grouped by service type and profession, such:
    - Registered clinical psychologists currently access items 80000–80021 for psychological therapy services.
    - Non-clinically endorsed registered psychologists, occupational therapists with mental health training and accredited mental health social workers currently access items 80100–80135 for focused psychological therapies (FPS).
    - GPs who meet the appropriate credentialing requirements currently access items 2721–2727 for FPS.
    - Mental health nurses do not have MBS Better Access items, but they received funding to provide clinical nursing and care coordination services for those with severe disorders under the MHNIP up until June 2016. They are currently providing psychological services under programs commissioned through PHNs, as well as psychological services under GPMPs.
    - Other mental health professionals such as counsellors and psychotherapists registered under the Australian Register of Counsellors and Psychotherapists (ARCAP) do not have MBS Better Access items.
- Members of the MHRG disagreed on whether the current item and rebate structure should be changed. Members disagreed on the implications:
    - of different training and qualifications and, in the case of psychology, areas of practice endorsement for access to items and rebates
    - of AHPRA registration and protected titles for access to items and rebates, and

- on whether additional professions should be eligible to provide services under the MBS Better Access items.

- The MHRG agreed that these questions were not resolvable within the timeframe and resources available to the MHRG. Part of this disagreement reflects a debate within the psychology community that extends beyond the structure of the MBS. Members noted that a review of the evidence and arguments for and against the various perspectives would require significant resources to process and evaluate. The MHRG agreed that there was a risk of not progressing with recommendations on other important topics related to mental health services within the MBS if this topic became the focus of the MHRG.
- The MHRG agreed that this is a critical issue and that the new working group or committee tasked with resolving the issue should be formed carefully, giving due consideration to membership. The MHRG agreed that resolution of this issue is a matter of urgency, given the influence of MBS rebates on patient access to mental health services.

MHRG Recommendation 4 – Endorsed for Government consideration

Acknowledging the historical debate within the mental health provider community concerning Better Access MBS items, the Taskforce supports the recommendation to establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups.

The Taskforce further notes that:

a. the group would need adequate time and resources to complete its mandate,

b. government would need to carefully consider membership of the group to ensure unbiased, balanced and well-informed discussion and recommendations, and

c. this new group should be established urgently to maximise value for the patient and the health system.

Recommendation 5 – Reduce minimum number of participants in group sessions

The MHRG recommends:

a. reducing the minimum number of participants in group sessions (items 80020, 80120, 80021, 80145, 80146, 80170 and 80171) to four people

b. clarifying that family and couples therapy is not included under the group therapy items, and

c. amending the proposed item descriptor (using psychology as an example) is as follows:

Revision to descriptors – example text

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration, where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a GP, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and

management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year, all of which may be provided via video conference (including services to which items 80020, 80021, 80120, 80121, 80145, 80146, 80170 and 80171 apply).

Group therapy with a group of 4 to 10 patients.

Rationale 5

This recommendation focuses on increasing the uptake of group sessions by making them more accessible, viable and responsive to the needs of patients. It is based on the following:

- The MHRG agreed that group-based therapies are both effective and cost-effective. There are many published research reports supporting the efficacy of group-based therapies, e.g. for the treatment of depression (13; 14; 15).
- Group therapy has a long tradition in mental health service delivery, including psychodynamic groups, encounter groups, family groups, mindfulness-based cognitive therapy (MBCT), and a wide range of symptom-specific cognitive and behaviour change groups for generalised anxiety disorder (GAD), depression, social anxiety, post-traumatic stress disorder (PTSD), anger management, panic, agoraphobia, hoarding disorder, obsessive compulsive disorder (OCD), social skills training, problem-solving therapy (PST), weight management and eating disorders.
- The uptake of group work items in the MBS should be higher, given the proven effectiveness of group therapy and the greater access to services it provides.
- The existing M6 and M7 items for group therapy are hampered by limiting patient attendance numbers to six to 10 people. This is restrictive and impractical, particularly in rural settings, where it is difficult to get six people to attend due to challenges associated with travel, fluctuating participant motivation and wellness.

MHRG Recommendation 5 – Endorsed for Government consideration

The Taskforce supports this recommendation and the MHRG's rationale.

Recommendation 6 – Add a new group item for therapy in larger groups

The MHRG recommends adding a new group item (801AA) for psychological services in larger groups to cover 11 or more patients, with one or two therapists in attendance, with the proposed item descriptor as follows:

New item – example descriptor

Professional attendance for the purpose of providing psychoeducation or skills training for an assessed mental disorder by one or mental health therapists, lasting for at least 60 minutes with a group of 11 or more patients.

Two therapists should be in attendance for any patient group greater than 15.

These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year.

Rationale 6

This recommendation focuses on ensuring efficient opportunities for psychological services and increasing the cost-effectiveness of group therapies. It is based on the following:

- The MHRG agreed that some group therapies could be effectively delivered in larger group settings. Examples included mindfulness, acceptance and commitment therapy, relaxation groups and goal-setting groups (16).
- MBCT was developed with a specific focus on preventing relapse/recurrence of depression. It can be delivered as an eight-week group program, with eight to 15 patients per group (17).
- Coping with Depression is a highly structured, multi-modal group psychoeducational treatment with a strong record of reducing the risk of major depression (14).

MHRG Recommendation 6 – Not endorsed for Government consideration

The Taskforce agrees that a large group therapy session is unlikely to be effective.

The Taskforce notes limitations in the fee-for-service model in promoting longitudinal care and addressing patient complexity, and agrees further research should be undertaken on evidence-based models of successful non-MBS group therapy. Such evidence could inform consideration of non-fee for service solutions.

Longer-term recommendations

Recommendation 7 – Enable family and carers to participate in therapy and/or consultation

The MHRG recommends:

a. amending the item for psychological therapies and FPS (items 80000–80015, 80100–80115, 80125–80140 and 80150–80165) to allow sessions with family members, guardians, carers and/or residential staff, where:

   (i) The identified patient is not present.

   (ii) The primary focus is the identified patient's treatment or assessment needs.

   (iii) The decision to use sessions (as outlined above) is made by the identified patient (or the patient's guardian, if the patient is a minor or if guardianship is in place; or the patient's nominated representative if the patient does not have legal capacity to provide informed consent).

   and

b. introducing a new item for the specific purpose of enabling consultation between health professionals and carers and/or support people, with the proposed item descriptor as follows:

New item – example descriptor

Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period.

Note: Recommendation 7a is intended to provide more immediate access in the short term with Recommendation 7b able to replace Recommendation 7a in the longer term, with a view to creating a more flexible future for psychological therapies under the MBS.

Rationale 7

This recommendation focuses on delivering the most efficient therapies in order to achieve the best possible outcomes. It is based on the following:

- In many situations, a fundamental element of evidence-based best practice in the delivery of psychological therapies is the provision of sessions for carers. These sessions are not currently eligible for a Medicare rebate if the "identified patient" is not physically present.
- Many submissions to the MBS Review recommended that the MBS mental health items provide for consultation between mental health professionals and carers/support people wherever appropriate, with the aim of enhancing collaboration, increasing engagement and recognising carers/support people as valuable resources. In some cases, group and individual service delivery would be relevant for carers.
- The importance of family and carer sessions can be underlined by looking at patient subsets within an MHTP:
    - Children and adolescents with an MHTP: The inclusion of one or more parent/carer-only session is a standard component of child and adolescent psychological therapy. Parenting/carer approaches, parenting skills and parental attitudes to the attributes of their child can seriously affect the child's wellbeing, and it is likely to be detrimental to discuss these with the child present. Parents/carers also need to develop more positive approaches to child management and need to have the rationale for these addressed at an adult level without the child present (18).
    - People living with dementia and/or in residential aged care with an MHTP: The recommendations made by the Senate Inquiry into Care and Management of Younger and Older Australians Living With Dementia and Behavioural and Psychiatric Symptoms of Dementia (BPSD) strongly supported the value of and need for carer involvement in therapy (19). The report noted that training family caregivers in behavioural management techniques is effective in reducing depression.
    - People with intellectual disabilities with an MHTP: The University of NSW's *Guide to Accessible Mental Health Services for People with an Intellectual Disability* emphasises the importance of a collaborative partnership between family and carers, the person with an intellectual disability, and providers of health and disability services (20).
- The importance of informed patient consent (where the patient has legal capacity to provide consent) in relation to the engagement of carers was emphasised, in order to preserve the confidentiality and boundaries of the therapeutic relationship between the provider and the identified patient.
- For specific patient groups, it may be appropriate for most sessions to be provided directly to the carer without the identified patient present, e.g. children (such as infants and children under three years of age) and some adolescents and adults with significant cognitive impairment related to intellectual disability, dementia and/or a mental disorder. For all other patient groups, the importance of restricting the number of carer-only sessions provided under the MBS mental health items was emphasised, with a suggested limit of 20 per cent of the patient's available sessions for the 12-month period.
- Recommendation 7b proposes a new item for family and carer services. This would bring psychology and allied mental health providers in line with psychiatry and could parallel item 352.

MHRG Recommendation 7 – Endorsed (with amendment) for Government consideration

The Taskforce acknowledges the rationale presented by the MHRG and recommends amending the item for psychological therapies and FPS items 80000–80015, 80100–80115, 80125–80140 and 80150–80165) to allow sessions with family members, guardians, carers and/or residential staff, where:

a. the identified patient is not present,

b. the primary focus is the identified patient's treatment or assessment needs, and

c. the decision to use sessions is made by the identified patient (or the patient's guardian, if the patient is a minor or if guardianship is in place; or the patient's nominated representative if the patient does not have legal capacity to provide informed consent).

Note: The Taskforce does not support the creation of a new item, noting that this should be done using evidence gathered from implementing the short-term changes (above) in an MSAC application.

Recommendation 8 – Measure Better Access outcomes

The MHRG recommends that:

a. the Government invest time and resources in building outcomes measurement into the MBS as mental health, and the Better Access program in particular, could provide an arena for a trial of outcomes measurement within the MBS and provide an opportunity to test the response of consumers to regulated outcomes monitoring, and

b. the outcomes measures used for Better Access should be:

   (i) Consistent: To the extent possible, the same measures should be used across all sectors and funding systems in the mental health space (for example, the MBS, PHNs, non-governmental organisations (NGOs), state health services).

   (ii) Comprehensive: Ideally, outcomes measures would incorporate holistic measures as well as covering clinical symptoms, functioning, morbidity, quality of life, patient satisfaction, clinical governance processes, the evidence base for interventions, and psychosocial and environmental impact.

   (iii) Carefully implemented: Measures should have high uptake and should result in behaviour change, rather than simply serving as tracking tools. Training and incentives for use (at least initially) could support this.

   (iv) Flexible: Multiple stakeholders at multiple levels should be able to use measures to improve quality of care. This includes health care providers, consumers and policy makers.

Rationale 8

This recommendation focuses on collecting data to help ensure that patients are improving as a result of mental health treatment, and to guide improvements in services into the future. It is based on the following:

- Monitoring outcomes in psychological therapies is recognised as important both for the welfare of the client and to confirm the effectiveness of treatment (21). Outcomes are already measured within mental health services in Australia (22). However, there are inconsistencies in both the use of outcome measures and the measures themselves.

- While the MHRG noted that some (and maybe even most) mental health providers use some sort of outcomes measure, there is variability in the implementation, sustainability and subsequent use of routine outcome data (23).
- The MHRG also noted variability in the measures themselves. Some measures are used by public and community health services in Australia, but the MHRG noted that there are cases where different measures are appropriate. It agreed that it is important to have both "routine outcomes measures" and a range of outcome measures for specific purposes.
- The MHRG identified two reasons for inconsistencies in outcomes measurement: inadequate infrastructure to develop and implement quality measures and the lack of a cohesive strategy to apply mental health quality measurement across different settings.
- While the MHRG did not specify the measurement tool to be used by mental health providers within the MBS, members noted several possibilities and agreed that the selected tool should reflect the priorities outlined in the recommendation and repeated below:
    - Consistent measures: Coordinating a culture of measurement-based care would enhance the quality and outcomes of mental health services across different mental health provider groups, including medical practitioners, psychiatrists, psychologists, accredited mental health social workers, nurses, occupational therapists and other health professionals.
    - Comprehensive measures: These are less likely to present a skewed view of outcomes. In particular, the MHRG noted that most measures focus on mental illness; far fewer assess mental health (24).
    - Carefully implemented measures: The MHRG noted that many outcome measures already exist. The challenge is in developing structures and processes to ensure that these measures contribute to a feedback loop that helps clinicians better target their therapies to achieve better health outcomes for patients.
    - Flexible measures: Measures that can be used and understood by multiple stakeholders are more likely to succeed, and to have lower costs, than a series of different measures developed for different contexts.
- The MHRG noted that outcome measures would support feedback-informed treatment. This leverages feedback from the patient on both psychological function and the therapeutic alliance to improve treatment (25).
- The MHRG noted that there could be advantages to this recommendation beyond directly improving treatment outcomes for consumers. For example, outcome monitoring could enable large-scale outcome studies.
- The MHRG recognised that developing structures and processes for outcome measurement within the MBS would have an associated cost and, no matter how streamlined, would likely add to the administrative burden for individual providers and for the MBS as a whole.
- Part of the function of PHNs is collecting, collating and analysing data to be reported back to DoH, which adds to their costs. The MBS does not have this function, which means that whatever data is tracked is not used productively. For example, the MHTP provides space to track an approved outcome measure, but the data is not collected and analysed.
- The MHRG discussed the possibility of making compliance with the collection of outcome measures data mandatory for approval to deliver item numbers under the MBS.

MHRG Recommendation 8 – Endorsed for Government consideration

The Taskforce support this recommendation and the MHRG's rationale.

Recommendation 9 – Update treatment options

The MHRG recommends updating treatment options by:

a. adding all therapies (items 80000–80171) with NHMRC Level I or Level II evidence to the list of approved therapies under Better Access,

b. updating the terminology for Better Access services for consistency across service providers, renaming items 80100–80171 as 'psychological therapy services',

Note: The Chair of the MHRG noted his dissent from the recommendation to rename items 80100-80171.

c. frequently review and update the list of therapies covered under the MBS based on evolving evidence of effectiveness, and

d. adding the following therapies to the Better Access list of approved psychological interventions:

(i) ACT.

(ii) Dialectical behaviour therapy.

(iii) Emotion-focused therapy.

(iv) Eye movement desensitisation and reprocessing.

(v) Family intervention (FI).

(vi) Psychodynamic therapy.

(vii) Metacognitive therapy.

(viii) MBCT.

(ix) Schema-based therapy.

(x) Solution-focused therapies.

(xi) Exposure treatments.

(xii) Narrative therapy.

(xiii) Narrative exposure therapy.

(xiv) Trauma-focused cognitive behaviour therapy.

Rationale 9

This recommendation focuses on aligning the MBS with current evidence. It is based on the following:

- The MHRG discussed whether to include an exhaustive list of all therapies, or to instead note that any other therapies with strong evidence (Level I and Level II) could be provided. (Currently, items 80000–80021 have a non-exhaustive list, while items 80100–80171 have an exhaustive list.) The MHRG did not reach consensus on this question.

- The MHRG also discussed the value of other evidence (i.e. evidence that is not classified as Level I or Level II) for some therapies. It noted that the NHMRC has outlined specific conditions under which Level III studies may provide a good evidence base that can be trusted to guide practice in most situations (26).
- The current list of FPS/psychological therapies is out of date and does not reflect current evidence. Many psychological therapies that have demonstrated a sufficient evidence base are not included in this list.
- The range of therapies for which an MBS rebate is available should be expanded to better meet patients' needs. The MHRG noted that patients receiving treatment from a range of mental health practitioners (who are appropriately trained to deliver the therapies listed in this recommendation) should have access to these therapeutic approaches, in line with current best-practice evidence.
- Mental health providers under both sections of the MBS are expected to provide evidence-based psychological therapies within their scope of practice. All providers should therefore be considered as providing "psychological therapies", as opposed to "focused psychological strategies".
- Some therapies show promise but have yet to meet the required level of evidence (for example, dignity therapy). Others may be considered effective today but may not be in the future. For this reason, it is important that the MBS:
    - Continues to review the evidence for different psychological therapies.
    - Updates evidentiary standards, as reflected in NHMRC guidelines, where appropriate (26).

MHRG Recommendation 9 – Endorsed (with amendment) for Government consideration

The Taskforce supports the rationale provided by the MHRG and recommends an evaluation of eligible therapies under Better Access by:

a. reviewing therapies currently omitted from Better Access that meet the NHMRC Level I or Level II evidence requirements,

b. creating a list of therapies omitted from Better Access with NHRMC Level I or Level II evidence and submitting it to MSAC for consideration and subsequent addition to the list of approved therapies under Better Access (items 80000–80171),

c. updating the terminology for Better Access services for consistency across service providers by renaming items 80100–80171 as 'psychological therapy services', and

d. frequently reviewing and updating the list of therapies covered under the MBS based on evolving evidence of effectiveness.

Rationale

Currently, items 80000–80021 (psychological therapies) have a non-exhaustive list, while items 80100–80171 (FPS items) have an exhaustive list. The current list of FPS/psychological therapies is also out of date and does not reflect current evidence.

Recommendation 10 – Unlink GP focused psychological strategy items from M6 and M7

The MHRG recommends:

a. unlinking GP FPS items (items 2721-2727) from M6 and M7 items to enable GP FPS items to be provided in addition to M6 and M7 items, rather than within the allocated number of sessions under M6 or M7,

b. still restricting access to GP FPS items to patients with an MHTP,

c. the maximum number of allowable GP FPS items per patient should still be capped,

and

d. the maximum number of sessions should be per 12-month period, as opposed to per calendar year.

Notes:

- The MHRG noted that this recommendation would interact with Recommendation 1, and that patients at risk of mental illness would also have access to GP FPS sessions.
- The MHRG noted the interaction with Recommendation 9 in simplifying the language used to refer to psychological services provided to patients under the MBS.
- The MHRG noted that where multiple providers are involved in care, collaboration should be promoted.

Rationale 10

This recommendation focuses on ensuring flexible access to care. It is based on the following:

- This recommendation increases access to psychological interventions in Australia.
- GPs play a key role in engaging the "unengaged" population in need of mental health care—i.e. the 65 per cent noted in the National Survey of Mental Health and Wellbeing as not accessing services for mental health problems (27).
- Facilitating use of items 2721–2727 encourages GPs to upskill in the use of psychological strategies and therapies, growing a psychologically minded primary care workforce.
- GPs can play a key role in stepped care models. They are well placed to offer lower-intensity interventions for less severe, high-prevalence conditions like depression and anxiety, freeing up other resources to be offered to patients where the potential benefit is much greater.
- Increased uptake of these items would improve patient access to psychological interventions (particularly in rural areas).
- The MHRG also discussed the interaction with Recommendation 3 when evaluating whether the appropriate cap for GP FPS sessions should sit at 10 sessions, or follow the same severity tiers proposed in Recommendation 3, enabling a different number of maximum sessions depending on the patient's tier level. The MHRG did not reach a decision on this point.

MHRG Recommendation 10 – Endorsed for Government consideration

The Taskforce support this recommendation and the MHRG's rationale.

Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness

The MHRG recommends:

a. not counting mental health sessions within the allied health sessions (referred as part of team care arrangements under a GPMP) as part of a patient's capped number of sessions (items 10956 and 10968),

b. item 10956 should not contribute towards the cap of five allied health sessions per year under a GPMP and have its own maximum number of sessions,

c. encouraging GPs to use the ICD-10 (and ICD-11 from 2022) in the identification of mental health concerns and illnesses for people with chronic and terminal illnesses,

updating the descriptor and explanatory note for item 721 (GPMP) to enable patients with severe mental illness who are at risk of chronic disease to have a GPMP and TCA alongside their MHTP, and

d. still retaining the ability to claim both a GPMP and an MHTP on the same day.

Rationale 11

This recommendation focuses on ensuring flexible access to care for those who need it most. It is based on the following:

- The interrelationship between mental illness and poor physical health is well established. This relationship contributes to worse health outcomes for both those with a chronic disease and those with a mental illness (28) (29). On the subject of depression, for example, an article published in the Medical Journal of Australia in 2009 noted: "Having a physical illness is one of the strongest risk factors for depression. Moreover, evidence now shows that depression is also a risk factor for physical illness and for early death. Thus, both the depression and the physical illness need to be considered if we are to understand the complexities of this association and the best ways to treat each." (30)
- A growing body of national and international research evidence demonstrates that mental health concerns for all people with chronic, advanced chronic and terminal illness are under-reported, underdiagnosed and poorly treated (31). For example:
    - Childhood chronic illness can severely impair psychosocial functioning and become a precursor to future mental health difficulties (32).
    - Mental illness in the terminally ill is under-diagnosed and undertreated. Having a life-limiting illness does not preclude the possibility of also having a pre-existing mental illness, or the possibility of mental illness developing as a result of the psychological impact of the diagnosis or prognosis. Many people experience symptoms of PTSD as a result of a serious complex medical condition.
        - O'Connor et al. (pp. S44–47) showed that 45.8 per cent of cancer patients were possibly depressed, 36.9 per cent were possibly anxious and about 25 per cent had probable combined anxiety and depression (33).
- Enabling a GPMP to be developed for people with severe mental illnesses, even if only at risk of chronic illness, would ensure that they can access appropriate support to prevent and manage that risk. For example, a 2015 review of 25 studies around the world found that people with schizophrenia are 2.5 times more likely to have diabetes compared with the general population. Similarly, high rates of, and risk for, metabolic syndrome have been documented in bipolar disorder, depression and other mental disorders such as post-traumatic stress disorder. Specific to psychosis, the rate of metabolic syndrome is 32.5 per cent, with rates of up to 60 per cent observed in those with a longer duration of illness and use of antipsychotic medication (28).
- Coordinating mental and physical health care for patients with both disorders not only optimises health outcomes but can also reduce hospitalisations and emergency department use (34; 35). The Fifth

National Mental Health and Suicide Prevention Plan states that "in addition to the personal cost of physical illness for people living with severe mental illness, the total cost to the Australian economy has been estimated at $15 billion per annum. This includes the cost of health care, lost productivity and other social costs." (6)

- The MHRG noted that Nurse practitioners (NP) are primary care providers, and those who specialise in mental health and psychiatry are well placed to deliver comprehensive physical and mental health assessment and treatment. The MHRG further noted that the most recent budget provided funding to improve both consumer and health professional knowledge and understanding of the scope of practice of MHNPs.
- The MHRG also noted the role of mental health nurses and nurse practitioners in this space, as their scope of practice covers both physical health and mental health assessment, monitoring and treatment.
- The MHRG acknowledges that this recommendation will have intersections with other item numbers e.g. chronic disease management items, and that the objective of the recommendation is to ensure that patients with complex physical and/or mental health needs are not disadvantaged.

MHRG Recommendation 11 – Not endorsed for Government consideration

The Taskforce agrees this would only increase the number of sessions available via a model of care that it does not believe is suitable at this time. Referral to relevant research initiatives is supported.

This recommendation has also been looked at as part of AHRG Recommendation 2.

Recommendation 12 – Promote the awareness of digital mental health and other low-intensity treatment options

The MHRG recommends promoting the awareness of digital mental health and other low-intensity treatment options integrated with therapist support. The MHRG discussed various options for, and challenges associated with, increasing uptake of low-intensity treatments. It decided that effective digital solutions exist, and that the important next steps would involve investigating the best solutions to complement MBS services.

Rationale 12

This recommendation focuses on flexible access to mental health services. It is based on the following:

- The MHRG noted both the cost-effectiveness and the access advantages of digital mental health and other low-intensity solutions.
- The Group discussed various options for, and challenges associated with, increasing uptake of low-intensity treatments. It decided that effective digital solutions exist, and that the important next steps would involve investigating which solutions to bring into the MBS fold and encouraging their use.

MHRG Recommendation 12 – Endorsed for Government consideration

The Taskforce supports this recommendation and the MHRG's rationale.

Recommendation 13 – Support access to mental health services in residential aged care

The MHRG recommends continued monitoring of new funding recently announced for residents in RACFs and it hopes that this funding decision results in:

a. greater awareness of the overlap between and management approach to terminal illness and mental health,

b. improved assessments of mental health conditions at RACFs,

c. a reduction in prescribed medications, and

d. improved equity of access to the MBS for consumers.

Rationale 13

This recommendation focuses on access to mental health services in aged care. It is based on the following:

- The MHRG noted that care and treatment in RACFs can sometimes be fragmented or erratic. There is no nationally consistent system for the delivery of mental health services to older people, the quality and accessibility of services vary from place to place, and rural and remote locations tend to be less well served.
- The MHRG welcomes the budget announcement regarding funding for residents in RACFs. This has been designated to fund services commissioned by PHNs to deliver a range of preventive, educative and other interventions to reduce the prevalence, severity and duration of mental health issues in residents in RACF's.
- However, it was the view of some members of the MHRG that previous experience with PHN funding suggests that there is often a lack of consistency or transferability across the programs implemented. Concerns related to this include uncertainty about the continuity of mental health programs under the PHN commissioning model, and about the provision of evidence-based mental health services for older people with severe and enduring mental health issues, or with co-morbid mental health and advanced chronic illness, terminal care issues, pre-existing mental health issues or substance use issues.
- The MHRG noted that the MBS could follow the example of DVA in enabling access to MBS rebates. This would enable access to rebates for mental health services for residents in RACFs, if their treating GP determines that they have a diagnosable mental disorder or are at risk of a developing a mental health disorder (as assessed by ICD-10, or ICD-11 once in force).
- Notwithstanding the new budget measures, allowing residents in RACFs to access the mental health clinician of their choice, or to continue seeing the treating mental health clinician from whom they were receiving therapeutic services prior to entering the RACF, provides these individuals with consistency and continuity of care. It also respects the therapeutic relationship that may have been established between the treating mental health clinician and resident prior to entering the RACF.
- The MHRG acknowledges the current work being undertaken in the Aged Care Royal Commission and the Group would support recommendations from the Commission including regarding patients with dementia in Residential Aged Care Facilities in the MBS mental health items.

MHRG Recommendation 13 – Endorsed for Government consideration

The Taskforce supports this recommendation and the MHRG's rationale.

Recommendation 14 – Increase access to telehealth services

The MHRG recommends a review of the recent announced expansion of access to mental health telehealth services in rural and remote areas in two years to:

a. assess whether it has delivered the hoped-for outcomes, and

b. ensure that the change is a permanent one and is not seen as a temporary emergency fix.

Rationale 14

This recommendation notes the MHRG's agreement with a recent decision to increase availability of telehealth services. It is based on the following:

- The MHRG agreed that telehealth services were high value care for patients. However, the MHRG agreed that there was a risk that this decision reflected a temporary change given the current state of drought and emphasised that this decision should permanently enable all Better Access sessions to be offered via telehealth.
- The MHRG discussed the recent announcement expanding access to telehealth services in rural and remote areas. The change, effective from 1 September 2018, allows eligible patients in rural and remote areas to access all of their Better Access sessions via videoconference (as opposed to seven out of 10 sessions (36).
- The MHRG supports telehealth access for people with disabilities, frail and elderly people and those residing in rural and remote areas, when accessed through their usual GP.

MHRG Recommendation 14 – Referred

This recommendation was referred to the Telehealth Working Group.

4.5.4 Mental Health Reference Group Stakeholder Impact Statement

Mental health consumers, carers and professionals are expected to benefit from the recommendations in this report. In making its recommendations, the MHRG considered the access that consumers and carers would have to high-quality mental health services.

Consumers and carers will benefit from a shift in the MBS mental health continuity of care model, aligning it with the national approach to the provision of stepped care. This will improve access to mental health services and update the approach to mental health service delivery based on the best available evidence, including:

- **Stepped mental health care:** The MHRG has recommended some changes to the fundamental approach to the delivery of mental health services, to align with the stepped care approach proposed by the National Mental Health Commission and included in the Fifth National Mental Health and Suicide Prevention plan.

  Opening up MBS mental health services to consumers at risk of developing a mental health disorder means that services will be provided early in the treatment pathway, aiding significantly in the prevention of more serious mental health disorders.

  Evolving the structure of MBS mental health services so that consumers can be triaged according to diagnosis, severity and complexity gives GPs and mental health professionals more freedom to match a patient's treatment pathway to their individual circumstances, particularly for more severe and complex consumers.

Considering how digital and low-intensity services can be provided through the MBS will further support a stepped care model within a fee-for-service arrangement.

- **Access and flexibility:** The MHRG has also recommended some changes to the way mental health services are accessed. These changes will make it easier for consumers to access services as and when they need them.

  Increasing the number of sessions available per referral will ensure that consumers and carers can focus on accessing needed treatment from mental health professionals and reduce any unnecessary interruption in service. In addition, these recommendations should reduce the burden on GPs associated with reviewing patients, acknowledging the importance of continued liaison and care coordination between mental health professionals and GPs throughout treatment.

  Making group sessions more efficient should increase access to these services. This is important as some forms of mental health treatment are more effectively provided in a group setting.

  Building on current government initiatives regarding the provision of mental health services to residents of aged care facilities, and through telehealth arrangements, is key to ensuring ongoing access to mental health services for people in rural and remote Australia and for the elderly.

- **Incorporating the latest evidence:** This is the first holistic look at the delivery of MBS mental health services since the Better Access program was introduced in 2006. The MHRG's recommendations on treatment options, outcome measurement, family and carer access, and treating the physical health of those with a mental health disorder will align the MBS with contemporary evidence.

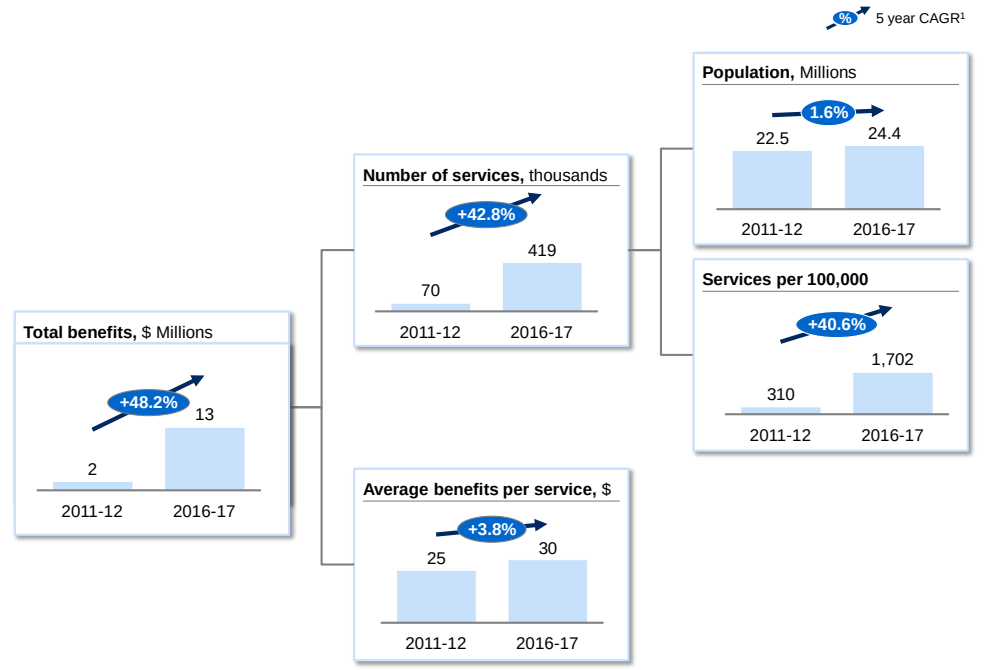
4.6 Nurse Practitioner Reference Group

4.6.1 Nurse Practitioner Reference Group's Areas of Responsibility

A list of all items reviewed by the NPRG can be found at Appendix B.

The NPRG reviewed 10 MBS items under *Category 8 Miscellaneous Services; Group M14 NPs 82200–82225*. These items cover professional attendances and telehealth services and are time tiered. In 2016/17, these items accounted for approximately 419,000 services and $13 million in benefits. Over the past five years, service volumes for these items have grown at 42.8 per cent per year, and average benefits per service have increased by 3.8 per cent compounded annually (Figure 21). In 2016/17, attendance by a participating nurse practitioner (NP) lasting at least 20 minutes had the highest service volume, accounting for approximately 133,000 services.

Figure 21: NPRG – Drivers of benefit growth (2011/12 to 2016/17)



1 Compound Annual Growth Rate
SOURCE: MBS data, 2011/12 – 2016-17

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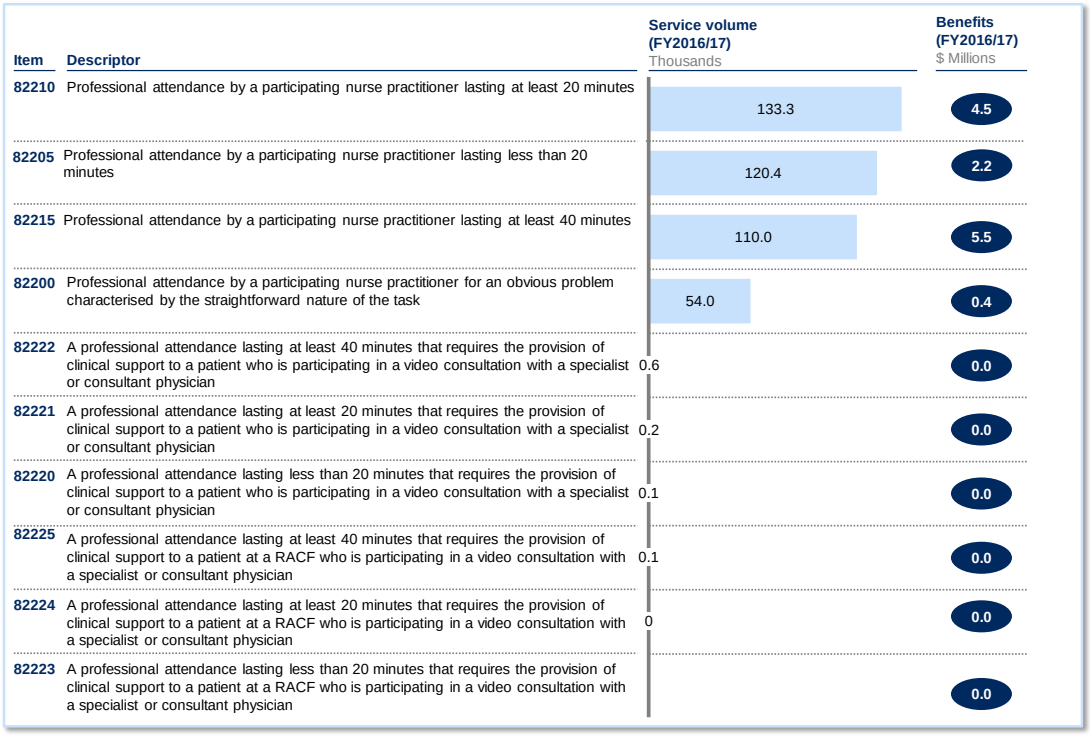
Figure 22: NPRG – In-scope items by service volume (2016/17)



SOURCE: MBS data, 2011/12 – 2016-17

4.6.2 Nurse Practitioner Reference Group's Review Approach

The NPRG completed a review of its items across four full meetings, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including

- data on utilisation of items (services, benefits, patients, providers and growth rates),
- service provision (type of provider, geography of service provision),
- patients (demographics and services per patient),
- co-claiming or episodes of services (same-day claiming and claiming with specific items over time), and
- additional provider and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through peer-reviewed nursing and medical journals and other sources, such as government reports and professional societies.

Key Issues

NPs have been practising in Australia for 18 years and were admitted as eligible providers under the MBS nearly a decade ago. Since that time, the interaction between the MBS and the NP role has not been reviewed for functionality, relevance to consumers, or its impact on the provision of and access to high-quality health care.

Models of care provided by NPs have the primary goal of improving access to care within the MBS, particularly in priority areas including aged care, Aboriginal and/or Torres Strait Islander peoples' health, mental health, chronic condition management and primary health care. Within these models, NPs may be the primary health care provider for a consumer or may be working as part of a team.

Despite the innovation and flexibility of these models, they remain curtailed by the limited number of items for which patients may receive MBS rebates when cared for by a NP. Rebates available to patients of NPs under the MBS do not reflect contemporary NP practice in Australia. This restricted access to MBS items limits consumer choice, affects accessibility, creates fragmentation and, at times, drives unnecessary duplication and costs throughout episodes of care.

The NPRG's recommendations are intended to address these limitations and improve patient access to high-value, best-practice primary health care. To do this, recommendations focus on ensuring that NPs are able to provide accessible and affordable services, in line with their full scope of practice.

Main themes

The role

Consistent with international experience, the NP role was implemented in Australia to improve the flexibility and capability of the nursing workforce and enable new ways of addressing identified service gaps across Australia's health care system. This initiative was driven by a clear need to improve access to care for marginalised, underserved and vulnerable populations.

An NP is a registered nurse (RN) whose registration has been endorsed by the Nursing and Midwifery Board of Australia (NMBA) under the *Health Practitioner Regulation National Law 2009* (the National Law). Endorsement as an NP signifies that the RN has completed the prescribed education and has the requisite experience to practise using the title of NP, which is protected under the National Law. To be eligible for endorsement, an applicant must meet the NMBA's *Registration Standard: Endorsement as a NP*. The minimum educational preparation for NPs is completion of a master of NP program, accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA.

The scope of practice

All health practitioners, including NPs, are expected to practice within the scope of health care delivery in which they have been educated and deemed competent. The scope of practice of the NP builds upon RN practice, enabling NPs to autonomously and collaboratively manage complete episodes of care, including wellness-focused care, as an independent primary provider of care or as part of a collaborative team.

NPs use primary and secondary health promotion and disease prevention principles in their care, as well as advanced, comprehensive assessment techniques in the screening, diagnosis and treatment of diverse acute and long-term health conditions. NP practice is evidence-based and includes the ability to request and interpret diagnostic tests; prescribe therapeutic interventions, including the prescription of medicines; and refer to other health care professionals. Collaborative and integrative in their approach, NPs use skilful and empathetic communication to facilitate person-centred care through the holistic and encompassing nature of nursing. NPs also evaluate care provision to enhance safety and quality within health care.

NPs practise in all clinical areas, across metropolitan, rural and remote Australia, in both the public and private sectors. With appropriate education and training, an NP can provide health care services across a broad context as a primary care provider for a patient. Alternatively, an NP may have more specialised education and training to provide expert care in a particular clinical specialty, such as emergency medicine, palliative care or renal medicine. While the role is clinically focused, NPs are also expected to actively participate in research, education and leadership in clinical care.

After extensive formative work demonstrating the ability to safely and effectively translate the NP role to the Australian context, the NP title was formalised and protected in Australia in 1998 through the *Nurses Amendment Act 2003* (NP Act). The first NPs were authorised to practise in NSW in 2000.

Since 2000, the Australian nursing profession has established the necessary professional and regulatory requirements to support the role, including:

- Professional standards for practice (1; 2; 3).
- The NMBA registration standard for endorsement under s95 of the National Law (4).
- NP course accreditation standards developed by the ANMAC (5).
- Professional representation through the Australian College of Nursing Practitioners.

In addition, NPs were admitted as eligible Medicare providers with the ability to participate in both the MBS and PBS in 2010 (6), enabling consumers to access rebates when choosing an NP as their health care provider. NP eligibility to participate in the MBS and the PBS is enabled by the *Health Legislation Amendment (Midwives and NPs) Act 2010*.

Differences between a registered nurse and a nurse practitioner

The NP role builds on the RN scope of practice. Table 14 broadly outlines the educational, professional and experiential requirements of the RN and NP scope of practice.

Table 1: NPRG Report – Registered nurse and NP scope of practice

	Registered nurse (RN)	Nurse practitioner (NP)
Practice requirements		
Title protection?	Yes	Yes
Regulation	Regulated under the National Registration and Accreditation Scheme (NRAS) by the NMBA Registration (RN): NMBA	Regulated under the NRAS by the NMBA Endorsement (NP): NMBA State/territory-based authorisation to account for jurisdictional legislation/policy where relevant (e.g. Poisons and Therapeutic Goods Acts). A total of three years full-time equivalent (FTE; 5000 hours) experience working at the advanced practice level (7) is required prior to endorsement by the NMBA.
Regulatory standards and guidelines	Registered Nurse Standards for Practice (8) NMBA Code of Conduct for Nurses (9)	Registered Nurse Standards for Practice NMBA Code of Conduct for Nurses NP Standards for Practice (9) Safety and Quality Guidelines for NPs (10)
Mandated collaborative arrangements	No	Legislated as a requirement for patient access to MBS and PBS rebates for NP services (11)
Requirements for entry into degree program	Completion of secondary education	Bachelor of nursing Postgraduate qualification at Australian Qualifications Framework (AQF) Level 8 in a relevant clinical specialty area
Experiential requirements for entry into degree program	N/A	Current general registration as an RN A minimum of two years FTE as an RN in a specified clinical field and two years FTE of current advanced nursing practice in this same clinical field
Length of education program	Three years FTE with 800 supervised clinical practice hours	Additional one to two years FTE with 300 integrated professional practice hours in addition

	Registered nurse (RN)	Nurse practitioner (NP)
		to 5000 hours (equivalent to three years FTE) required for endorsement
Level of educational program	AQF Level 7: bachelor's degree program	RN education program + AQF Level 9: master's degree program
Scope of Practice		
Formal diagnosis	No	Yes
Prescribing	No, although allowed to supply and/or administer under limited protocol in some public-sector settings (nurse-initiated medicines, standing orders and protocols)	Yes
Request/interpret diagnostic pathology	No, although some public-sector roles facilitate access to limited diagnostic pathology under the authority of a medical practitioner.	Yes
Request/interpret diagnostic imaging	No, although some public-sector roles facilitate access to limited diagnostic imaging under the authority of a medical practitioner.	Yes
Referral to medical specialists	No	Yes
Referral to allied health	Limited to within the public sector (e.g. nurse to physio referral for in-patients)	Yes, however NP referrals to allied health care are not currently subsidised by the MBS
MBS subsidy for services	No	Yes, for time-tiered professional attendances; telehealth; limited, simple, basic point-of care pathology; and limited plain-film X-Rays and ultrasounds
PBS subsidy for eligible prescribed medicines	No	Yes, with limitations.
MBS subsidy for therapeutic and diagnostic procedures	No	No
Admission rights	No	Yes, depends on local policy

Consumer Impact

The NPRG has developed recommendations that are consistent with the Taskforce's objectives, with a primary focus on improving patient access to affordable, high-value and best-practice primary health care provided by NPs, in line with their scope of practice.

Consumer representatives on the NPRG stressed the importance of patient choice in accessing primary care that is timely, uncomplicated, culturally safe and affordable. This is central to many of the NPRG's recommendations.

Patients will benefit from the NPRG's recommendations through improved access to continuity of primary care models and higher quality clinical services, particularly in aged care, chronic disease management, and rural and remote areas. This includes:

- **Improved access to primary care by a NP:** The NPRG has recommended a series of schedule fee changes throughout the report, which will facilitate access to NP care. Enabling patients to access an MBS rebate for NP care in after-hours and out-of-clinic settings will improve access, especially where other medical practitioners may not be available (including in palliative and aged care settings).
- **Removing inefficiencies and barriers to care:** Patients cared for by NPs are limited in the MBS items they can access under current MBS arrangements. The NPRG has made several recommendations to

enable patients to access MBS rebates for more complete episodes of care provided by NPs to reduce fragmentation and ensure high-value care and continuity of care across the health system.

- The NPRG's recommendation to remove collaborative arrangements focuses on improving access to affordable, universal and high-value care for patients by removing the mandated need for NPs to form collaborative arrangements in accordance with legislation. The existing legislative requirements impose an unnecessary additional impediment to NPs functioning as a flexible workforce initiative, which was the original intent of implementing the role almost 20 years ago.
- The recommendations to enable access to MBS rebates for NP-performed procedures and NP-requested diagnostic imaging will reduce duplication, delays and inefficiencies when a patient is referred to a medical practitioner for a procedure in order to access the MBS rebate to which they are entitled.
- **Improved patient access to telehealth services:** The NPRG has recommended a series of changes to telehealth services to improve access for patients:
    - Including GPs as eligible participants in NP patient-side telehealth services will support continuity of care through decreased wait times, particularly in remote areas where GP access is more limited.
    - Including patients in community aged care settings in residential aged care telehealth items will benefit patients in community aged care to receive care in a timelier manner.
- Patients who are unable to undertake video communication due to poor understanding of the necessary technology or infrastructure, particularly in remote areas, will benefit from the recommendation that allows telehealth consultations to take place via telephone where clinically appropriate.

Consumers, NPs and the Australian health care system will benefit from overall increased investment in NP continuity of primary care, as recommended in this report. These benefits will accrue from high-quality, cost-effective health outcomes that benefit families and the community.

4.6.3 Nurse Practitioner Reference Group Recommendations

Key recommendations

The NPRG's recommendations are listed below, organised into four overarching themes. The NPRG also identified four recommendations as areas of priority – Recommendations 1, 4, 8 and 9.

The NPRG's specific recommendations are as follows:

Support comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples.

1. Enable patients to access MBS rebates for long-term and primary care management provided by NPs.
2. Improve access to MBS rebates for NP services in aged care settings.
3. Enable Domiciliary Medication Management Reviews (DMMRs) and Residential Medication Management Reviews (RMMRs) to be initiated by NPs.

Enabling nurse practitioner care for all Australians.

4. Significantly increase the schedule fee assigned to current MBS NP professional attendance items to more appropriately reflect the complexity of care provided.
5. Create a new MBS item for longer NP attendances to support the delivery of complex and comprehensive care.
6. Enable patients to access MBS rebates for after-hours or emergency care provided by NPs to facilitate care provided in the most appropriate settings and in a timely manner.
7. Enable patients to access an MBS rebate for NP care received outside of a clinic setting.

Addressing system inefficiencies caused by current MBS arrangements.

8. Remove the mandated legislative mandated requirement for NPs to form collaborative arrangements in accordance with the National Health (Collaborative arrangements for nurse practitioners) Determination 2010.
9. Remove current restrictions on MBS-rebated diagnostic imaging investigations when requested by NPs working within their scope of practice.
10. Enable patients to access MBS rebates for procedures performed by an NP working within their scope of practice.

Improve patient access to telehealth services by expanding the scope of providers eligible to participate in consultations, and by broadening modes of communication.

11. Add general practitioners (GPs) as eligible participants in NP patient-side telehealth services.
12. Add patients in community aged care settings to residential aged care telehealth items.
13. Create new MBS items for direct NP-to-patient telehealth consultations.
14. Allow telehealth consultations to take place via telephone where clinically appropriate.

Note from the Taskforce:

The Taskforce acknowledges the important and valuable role of nurse practitioners in our healthcare system and supports expanded nurse practitioner services. The Nurse Practitioner Reference Group provided several examples in their report to highlight the diversity and quality of the care they provide.

Nurse practitioners are highly qualified and well educated in specific specialty areas, providing specialist nursing expertise to a variety of healthcare teams in hospitals and the community. In these specific areas they can diagnose, manage and treat patients as part of a collaborative arrangement.

It is important to make a distinction between credentials and scope of practice. Credentials are the qualifications (i.e. training, skills, and knowledge) and experience a nurse practitioner has acquired. Scope of practice is the specific specialty field in which those credentials can be exercised. The two terms are not synonymous.

As nurse practitioners are educated in specialty fields, their credentials do not allow them to transfer their diagnostic, treatment and prescribing skills to another specialty e.g. a renal nurse practitioner cannot assume a diabetic nurse practitioner role.

In response to the NPRG report, the Taskforce has made recommendations to attempt to resolve these issues via Additional Taskforce Recommendations.

Below are the recommendations from the NPRG's report. The recommendations seek to support comprehensive and coordinated care for persons particularly in priority areas including long-term health conditions, aged care, Aboriginal and Torres Strait Islander health, and mental health care.

The NPRG's recommendations are organised into four themes:

- Supporting comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples.
- Enabling nurse practitioner care for all Australians.
- Addressing system inefficiencies caused by current MBS arrangements.
- Improving patient access to telehealth services.

Supporting comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples

Case Study – Aboriginal and Torres Strait Islander Health

Susan is an NP working in an Aboriginal Health Service (AHS) in remote Queensland. She provides comprehensive primary and secondary health promotion and disease prevention and management services for consumers, many of whom have complex health requirements that are strongly influenced by the social determinants of health. Susan's primary health care services are augmented by the fact she has expertise in the assessment and management of people with kidney disease and diabetes. Many of her clients would greatly benefit from subsidised allied health services. In addition, many of her clients would benefit from enrolment in the Closing the Gap scheme, which provides subsidised prescriptions for Aboriginal and Torres Strait Islander clients.

Susan has infrequent and irregular access to a GP in her remote clinic. Although Susan has independently developed comprehensive management plans for her complex clients, which include referrals to allied health professionals, she is unable to appropriately operationalise them because NP referrals to allied health professionals are not currently available for rebate under the MBS. Her patients cannot afford to see the allied health specialists privately at the AHS, and the AHS cannot continue to provide these services without income generated by subsidised allied health appointments. In addition, current Department policy precludes her from enrolling patients in the Closing the Gap scheme or accessing its initiatives, which results in her patients paying higher out-of-pocket costs.

Recommendation 1 – Enable patients to access MBS rebates for long-term and primary care management provided by nurse practitioners

The NPRG recommends enabling patients to access MBS rebates for long-term and primary care management provided by NPs as follows:

a. amending the item 701, 703, 705 and 707 descriptors to include NPs as eligible providers, with proposed item descriptors (using item 701 as an example) as follows:

items 701 – example descriptor

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse practitioner, to perform a brief health assessment, lasting not more than 30 minutes and including:

a) collection of relevant information, including taking a patient history, and

a basic physical examination, and

initiating interventions and referrals as indicated, and

providing the patient with preventive health care advice and information.

b. amending the item 715 descriptor to include NPs as eligible providers, enabling Aboriginal and/or Torres Strait Islander patients to access MBS rebates for health assessments performed by NPs, with the proposed item descriptor as follows:

items 715

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse practitioner,, at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent - not more than once in a 9-month period.

c. amending the item 721, 723 and 732 descriptors to include:

(i) NPs as eligible providers, enabling patients to access MBS rebates for the preparation and review of CCMPs and the development of TCAs by NPs,

(ii) an appropriate title that captures the intent of the CCMP and TCAs (for example, Patient-centred Management Plan, chronic disease management Plan), and

(iii) with proposed item descriptor (using item 701 as an example) as follows:

item 721

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse practitioner, at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent - not more than once in a 9-month period.

Note: The NPRG notes that this recommendation may need to be amended to reflect proposed changes by the GPPCCC.

d. amending the item 729 and 731 descriptors to include NPs, enabling patients to access MBS rebates for an NP's contribution to a multidisciplinary care plan, with proposed item descriptor (using item 729 as an example) as follows:

item 729

Attendance by a medical practitioner (including a GP, but not including a specialist or consultant physician), or a nurse practitioner, for preparation of a chronic disease management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply)

Note: The NPRG notes that the GPPCCC referred a question on case conferencing to the NPRG.

e. amending the item 2700 and 2701 descriptors to include NPs as eligible providers,

f. that no MBS item or otherwise subsidised activities relating to the planning, coordination and management of long-term health conditions (for example, Closing the Gap initiatives, Home Medicines Reviews (HMRs), integrated team care) should result in greater disadvantage for Aboriginal and/or Torres Strait Islander patients seeking and choosing an NP to manage their chronic health condition, and

g. that any future iterations of MBS items, Commonwealth-subsidised models of care, or funding arrangements relating to the primary care management and coordination of long-term health conditions should consider that an NP may be a patient's preferred primary care provider, as a safe and effective alternative to a GP.

Rationale 1

This recommendation focuses on ensuring high-value care for patients with long-term, chronic health conditions and Aboriginal and/or Torres Strait Islander peoples. It is intended to avoid fragmentation, delays and other inequities in care for patients whose primary health care provider is an NP. It is based on the following:

- The burden of chronic illness is growing in Australia, placing increasing pressure on the health system. This pressure is particularly felt within the following populations:
    - Aboriginal and/or Torres Strait Islander peoples: Chronic diseases were responsible for 64 per cent of the total disease burden among Aboriginal and/or Torres Strait Islander peoples in 2011 (12). There is a high burden of avoidable death among Aboriginal and/or Torres Strait Islander peoples.
    - Homeless populations: People experiencing homelessness are less likely to access primary and preventive health services (13). This increases the risk of later-stage diagnosis of disease (14), poor control of manageable conditions (for example, hypertension, and diabetes) and hospitalisation for preventable conditions (for example, skin or respiratory conditions).
    - Aged care: Care is provided not only in RACFs but increasingly in the home and community setting. Many of the residents of aged care facilities have complex health care needs. While the RACF population is growing rapidly, the number of GPs providing care in these facilities may be declining (15).
- All patients, but particularly the marginalised groups outlined above, should be supported and enabled to access health care provided by appropriate models of care, including NPs (16). There are specific considerations for the Aboriginal and Torres Strait Islander health assessment item 715. It is specifically focused on Aboriginal and/or Torres Strait Islander populations and is conducted across the lifespan of patients. When a medical practitioner conducts an item 715 health assessment service, it enables several important, subsidised health services. These services help mitigate the risk of developing chronic health conditions, assist with the early identification of such conditions, improve the quality of preventive care provided, and reinforce the requirement for multi-level care for this vulnerable population. This includes access to:
    - Culturally appropriate care using subsidised enhanced follow-up services offered by nurses and Aboriginal and Torres Strait Islander health practitioners. These services are rebated through MBS item 10987.

  - Subsidised enhanced care services using allied health and Aboriginal and Torres Strait Islander health workers. These services are rebated through MBS items 81300–81360. In many instances, income generated from nurses, Aboriginal and Torres Strait Islander health practitioners, and allied health workers through use of these items is not only used to pay for their professional services, but also supports Aboriginal Community Controlled Health Centres and Aboriginal Health Services.

  - Closing the Gap initiatives, including integrated team care funding through primary health networks, medication supply subsidies and practice incentive program payments that enhance service delivery for all Aboriginal and/or Torres Strait Islander peoples. Importantly, practice incentive payments relating to the item 715 health assessment support ongoing infrastructure and human resource requirements for the delivery of health care for Aboriginal and/or Torres Strait Islander peoples. Excluding NPs from these initiatives results in significant disadvantage for Aboriginal Health Services using the services of NPs.

- NPs working with Aboriginal and/or Torres Strait Islander peoples, whether in metropolitan or remote health services, are unable to provide these subsidised health services because they are not considered eligible providers under MBS item 715. They are unable to facilitate subsidised allied health care, culturally safe Aboriginal and Torres Strait Islander health worker support or Closing the Gap pharmaceutical rebates for their patients. The lack of access to these rebates results in patients receiving no clinical care, or little or fragmented clinical care, and in further marginalisation of an already vulnerable group.

- NPs in Australia provide high-quality case management, care planning and care facilitation services for people with long-term health conditions. Their ability to diagnose, request and interpret diagnostic investigations, prescribe medicines and initiate referrals to other health professionals means they are well placed to serve as a primary provider of care for people with long-term health conditions.

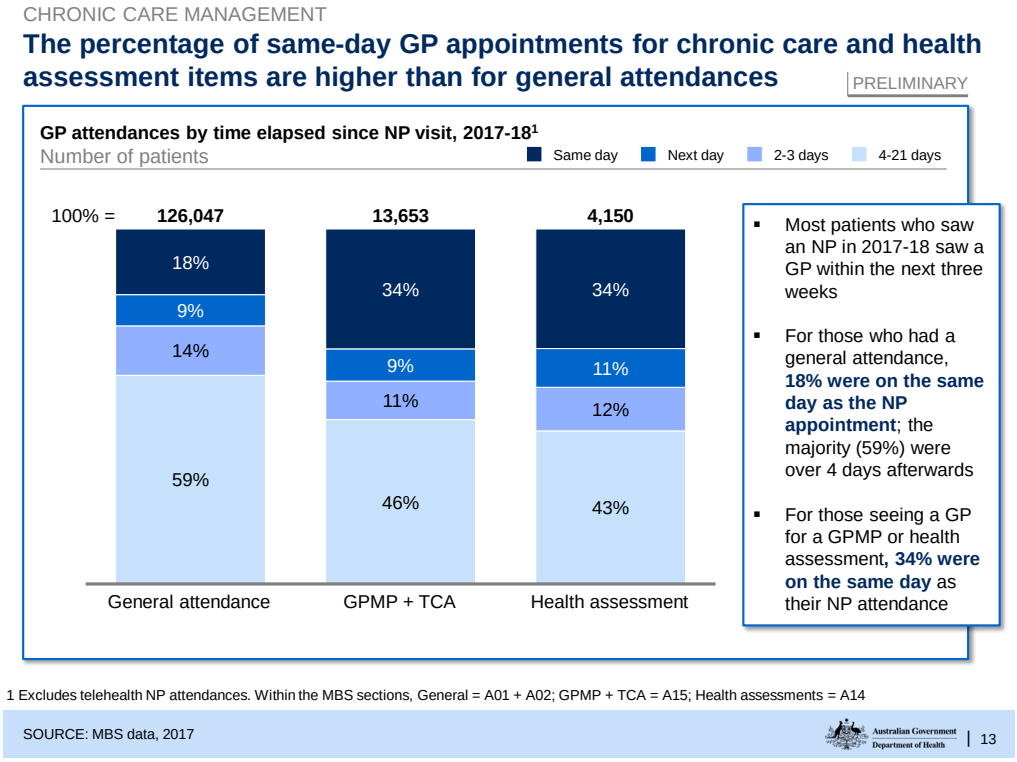
- Inequity in funding mechanisms should not prevent people from receiving comprehensive, evidence-based care. Current MBS restrictions limit patient choice and result in fragmented care. They also prevent health services from optimising NPs—an underutilised resource in Australia's health care system.

- Patients who choose an NP as their health care provider are unable to access MBS rebates and as a result are limited in their choice of provider. This is particularly problematic where access to a medical practitioner is limited, and for marginalised and vulnerable populations.

- Current restrictions result in fragmented and delayed care for NP patients, as the NP must refer a patient to a GP for a chronic disease management Plan, MHTP or health assessment to be rebated under the MBS. While MBS data cannot indicate why a referral occurred (and whether it represented high- or low-value care), recent attendance data shows that same-day attendances with a GP following an NP attendance are higher for health assessment and GP Management Plan items than for general GP attendances (Figure 23). These restrictions unnecessary limit a patient's choice of provider in the management of their long-term health. These restrictions also create a financial disadvantage for health services that employ NPs to meet the needs of their communities.

- This recommendation may also have advantages from a system efficiency standpoint. Increasing point-of-care access to NPs will remove the need for onward referral for additional MBS services. This will reduce the current duplication and fragmentation experienced by many patients, particularly Aboriginal and/or Torres Strait Islander peoples and those from marginalised communities, improving system efficiency.

Figure 23: NPRG – Distribution of same-day attendances



Case Study – Residential Aged Care Facilities

Mark is an NP providing comprehensive clinical services to older people living in RACFs across the metropolitan area of Adelaide. He routinely sees residents who would not otherwise have access to timely primary care. A typical day may require Mark to assess, diagnose and treat minor or acute illnesses or injuries including infections, wounds, behavioural and psychological symptoms of dementia, musculoskeletal injuries and mental health episodes, or to provide end-of-life care. This can involve a range of interventions and care coordination; prescribing, titrating and/or ceasing medicines; ordering diagnostic investigations; and directly referring patients to other health professionals.

However, residents can experience delays in receiving necessary diagnostic investigations as current MBS rules do not enable NPs to initiate many common diagnostic imaging tests otherwise subsidised in primary health care, such as ultrasounds and X-rays. This leads to fragmented and unnecessary duplication of services, either requiring a second attendance by a GP, or worse, an unnecessary transfer to an emergency department.

Some residents may not have access to a GP who conducts comprehensive medical assessments or team care arrangements, including accessing allied health services. Residents then do not have their chronic health conditions proactively assessed and monitored for early signs of deterioration, increasing the incidence of acute events and hospitalisation or reducing their overall quality of life. Residents and RACF staff have asked Mark to assist in the provision of comprehensive health assessments, chronic disease management, case conferences and advance care planning. However, the allocated times for NP professional attendances (i.e. MBS items 82200–82215) are not practically useful for this care.

NPRG Recommendation 1 – Not endorsed for Government consideration

See overarching advice on scope of practice for nurse practitioners.

Recommendation 2 - Improve access to MBS-subsidised nurse practitioner services in aged care settings

The NPRG recommends enabling patients to access MBS rebates for NP services in aged care settings, particularly:

a. health assessments, which are available for residents of RACFs and those aged over 75,

b. health assessments for Aboriginal and/or Torres Strait Islander peoples,

c. Managing chronic disease,

d. Contributing to a multidisciplinary care plan, particularly for residents of RACFs (item 731), and

e. Developing a MHTP.

Notes:

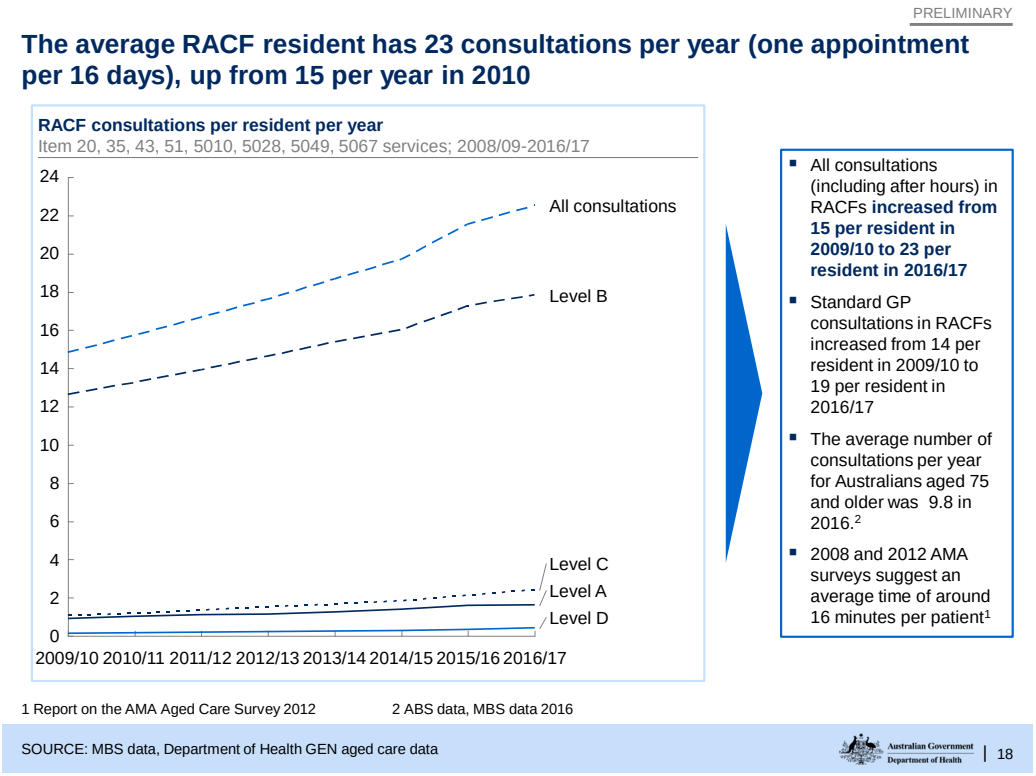
- This recommendation mirrors most of the recommended changes made at Recommendation 1.
- This recommendation also reinforces the importance of Recommendation 5 which proposes a new item for an NP professional attendance lasting for at least 60 minutes.

Rationale 2

This recommendation reiterates recommendations made elsewhere in the report to emphasise the importance of ensuring access to universal, affordable and coordinated care for long-term health conditions for patients receiving aged care services in residential and community settings. It is based on the following:

- Increasing levels of frailty and complexity in physical and mental health in aged care settings requires access to continuity of care from appropriately qualified clinicians.
- Ninety-seven per cent of permanent RACF residents (as of 30 June 2017) had medium or high-level needs for complex health care services, and 85 per cent had one or more diagnosed mental health or behavioural condition (17).
- There are limitations on the availability of primary care service provision in the aged care sector. Although MBS data shows increasing visits per patient in RACFs since 2010 (Figure 24), a recent survey of Australian GPs highlighted that over 35 per cent of the respondents who currently visit patients in RACFs intend to either not take on any new patients in RACFs, decrease their visits or stop visiting RACFs altogether (15).

Figure 24: NPRG – Residential aged care facility visits by GPs



- Many patients cannot continue to receive services from their usual GP after moving into an RACF, either because they have moved outside the GP practice's boundaries, or because the GP is unable or unwilling to visit RACFs (15).
- In the absence of timely, accessible primary care, these older people are often transferred to hospital emergency departments for treatment and/or admission. Delayed intervention may also result in avoidable deterioration in the older person's health status and the subsequent need for more intensive use of health resources.
- Consumer representatives on the NPRG also emphasised the limits this imposes on an older person's access to responsive, appropriate, quality primary care and the commensurate increase in stress for family carers and residential aged care staff.
- Permanent residents in RACFs or those receiving Home Care Packages in their homes cannot currently access MBS rebates for comprehensive medical assessments, chronic disease management Plans or other common MBS services when these are provided by an NP.
- NPs are effective providers of preventive and long-term care in the aged care sector. For example, a study funded by the Department of Social Services, which reviewed 30 organisations using different NP models of care (18), found that NPs:
    - Spent more time with patients than GPs and were more accessible and able to initiate more timely care.
    - Visited elderly people in their homes and thereby increased access to care for those who were not mobile or able to drive themselves to services.
    - Were able to review medicine regimes and, in some cases, reduce unnecessary polypharmacy.

- Played strong coordination roles in bringing together health professionals and family members and provided valuable translation of information into language the elderly person and their family could understand.

- In addition, economic efficiencies were gained through reductions in unnecessary transfers to acute health facilities, ambulance costs, hospital bed days and therefore hospital costs. The study estimated that extending the tested models of care to all aged care settings would have saved $97 million in 2013/14 from reductions in hospital bed days alone (18).

NPRG Recommendation 2 – Not endorsed for Government consideration

The Taskforce does not support this recommendation for Government consideration but acknowledges that this should be looked at again in the future following outcomes from the Royal Commission.

Similar to the overarching comments on scope of practice for NPs, there is currently a lack of clarity around scope of practice for NPs in a residential aged care setting, and the Taskforce agrees this needs to be addressed before this recommendation can be considered further.

There are also some structural issues around access for allied health professionals and chronic disease management items via RACFs that need to be addressed.

Ultimately, whatever model is proposed needs to support a longitudinal model of care, consistent with principles from the GPPCCC.

Recommendation 3 - Enable Domiciliary Medication Management Reviews (DMMRs) and Residential Medication Management Reviews (RMMRs) to be initiated by nurse practitioners

The NPRG recommends:

a. enabling patients to access MBS rebates for NP-requested medication management reviews (MMRs) and DMMRs, through items 900 and 903,

b. that the same rules that apply to GP-requested medication reviews should apply to NP-requested reviews, including gaining consent from the patient or carer, giving results to the patient, and developing a plan to assist the patient with managing the medication,

c. access to rebates for NP-initiated medication reviews should apply to both the NP and the pharmacy components of these reviews (whether via the MBS or a Sixth Community Pharmacy Agreement),

d. Pharmacist reports should be supplied to the NP where they are the patient's lead clinician, and

e. a copy of the DMMR/RMMR should be uploaded to My Health Record, with permission from the patient (or legal substitute decision-maker).

Rationale 3

This recommendation focuses on increasing access and reducing fragmentation of care. It is based on the following:

- There are a significant number of hospital admissions due to medication-related misadventure. In its 2013 literature review on medication safety, the Australian Commission on Safety and Quality in Health Care stated: “Medication-related hospital admissions have previously been estimated to comprise 2 per cent to 3 per cent of all Australian hospital admissions, with rising estimates of prevalence when sub-populations are studied. For example, 12 per cent of all medical admissions and 20 per cent to 30 per

cent of all admissions in the population aged 65 years and over are estimated to be medication-related."(19)

- Increased use of DMMRs/HMRs and RMMRs can improve medication management and reduce hospital admissions by providing comprehensive care and risk management.
- These reviews are sometimes overlooked, delayed or prevented where access to a GP is limited.
- Enabling rebates for NP-requested MMRs will assist with reducing the delays in care noted above, medication misadventure and the risk of medication-related hospital admissions.
- Enabling rebates for NP-requested MMRs will also help to ensure continuity of care for patients.
- A patient's risk increases when they see multiple providers who may prescribe medications. It is essential that the patient has a lead clinician acting as care gatekeeper to help manage and coordinate their health (including management of medications), and to seek further advice as needed.
- This is particularly true for marginalised groups who have trouble accessing GP care and are often treated by NPs, providing consistency in care giving and building trusting relationships is a key concern for these groups.
- This is also true for patients in outer rural and remote areas, who may not have regular access to a GP. Some primary care clinics are managed by an NP, who functions as the senior/lead clinician and the consistent point of contact for patient care and chronic disease management coordination.

NPRG Recommendation 3 – Not endorsed for Government consideration

The Taskforce agrees this recommendation is better placed for submission to MSAC than for consideration through the MBS Review process.

Enabling NP care for all Australians

Recommendation 4 – Significantly increase the schedule fee assigned to current MBS nurse practitioner professional attendance items to more appropriately reflect the complexity of care provided

The NPRG recommends significantly increasing the schedule fee assigned to current MBS NP professional attendance items (items 82200, 82205, 82210 and 82215).

Rationale 4

This recommendation focuses on ensuring that attendance items reflect best practice and enable the provision of high-quality care to underserved populations. It is based on the following:

- This will enable patient access and choice and promote workforce sustainability in the primary health care setting.
- Current research highlights the role of NPs as providers of high-value primary care.
- There is a need to improve access to high-quality primary care in Australia, particularly in rural and remote areas, and for marginalised and vulnerable populations.
- In a recent study of GP clinics in northern NSW, almost 20 per cent of general practices could not offer an appointment, and less than 50 per cent could offer a same-day appointment (20).

- There are fewer MBS primary care attendances in rural and remote areas, compared to the rest of Australia (Figure 25).

Figure 25: NPRG – MBS attendances by primary care providers, by remoteness area

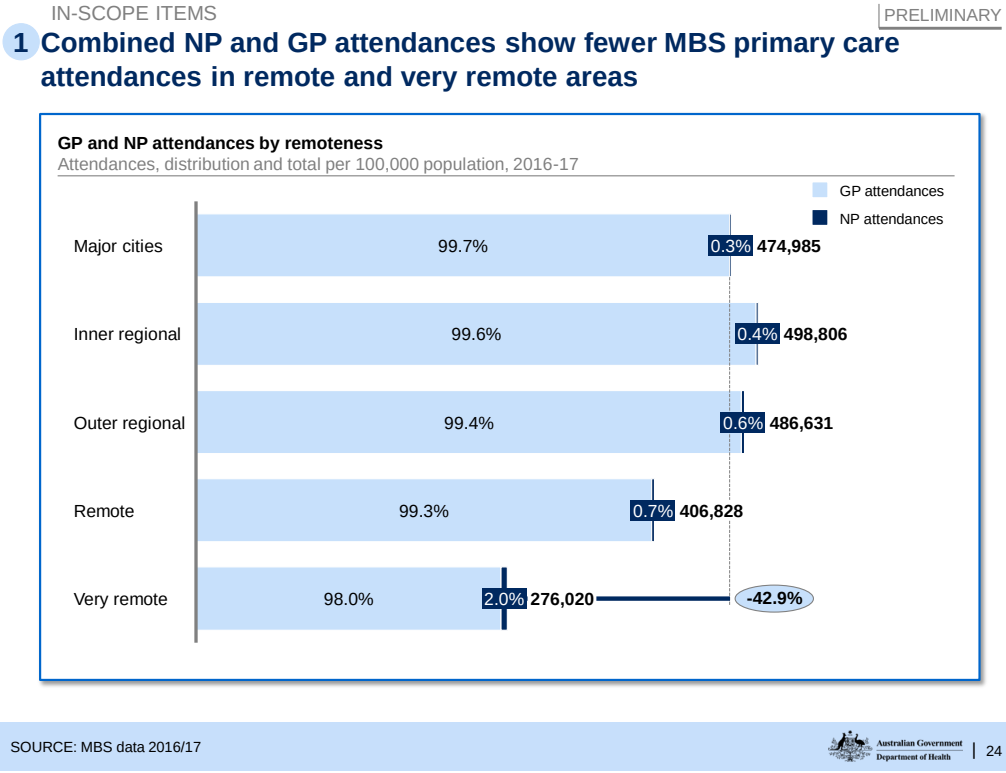
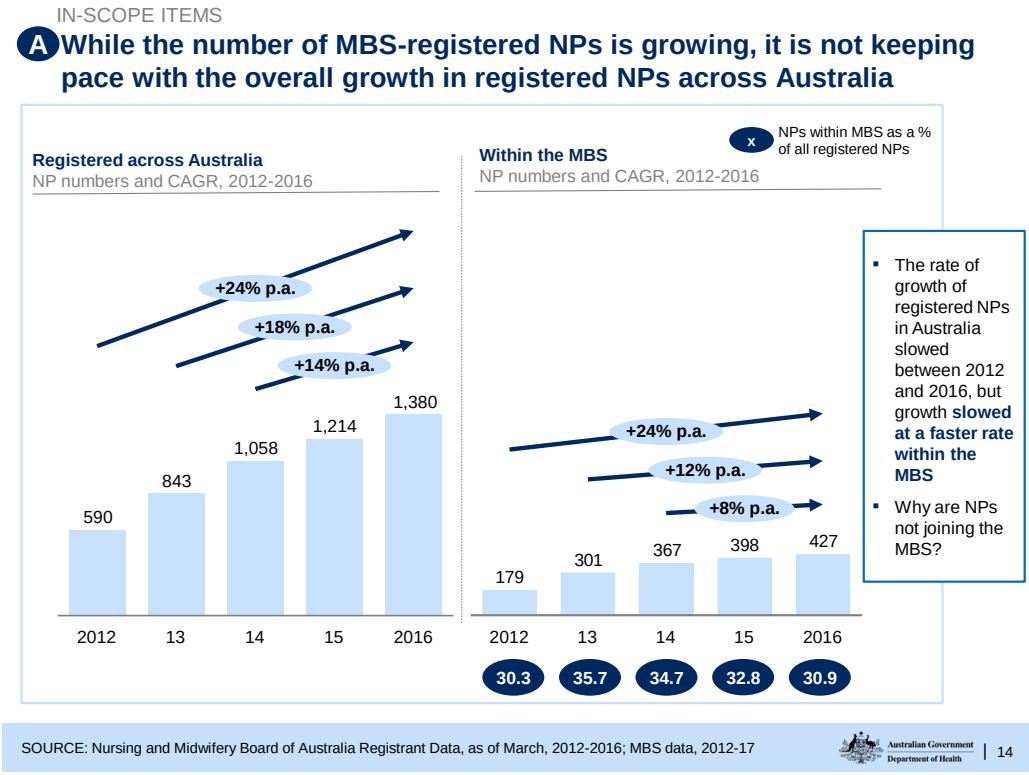


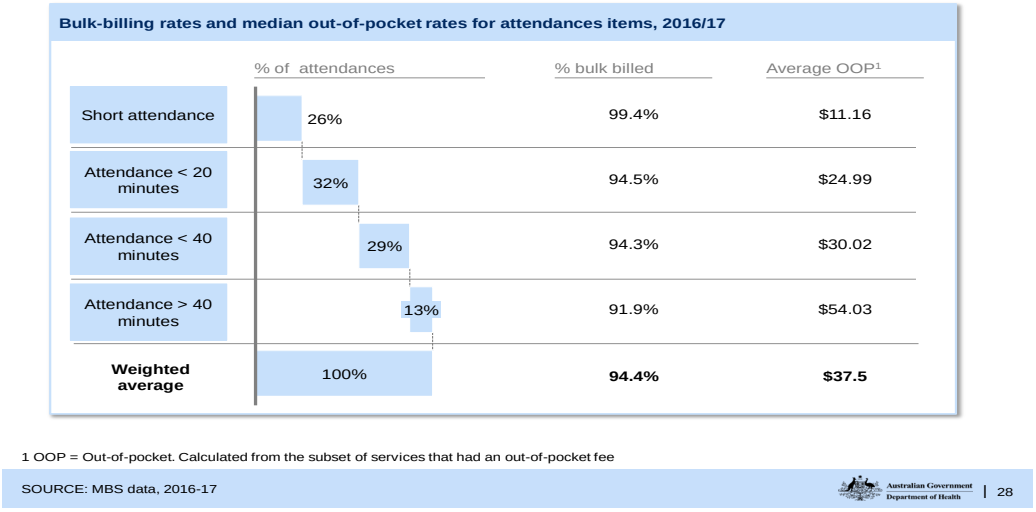
Figure 26: NPRG – Growth in NPs in Australia and within the MBS



- In Australia, the NP workforce is growing, but the rate of growth is slowing. Growth of the NP workforce within the MBS is slowing more dramatically, and from a much smaller base (Figure 26).

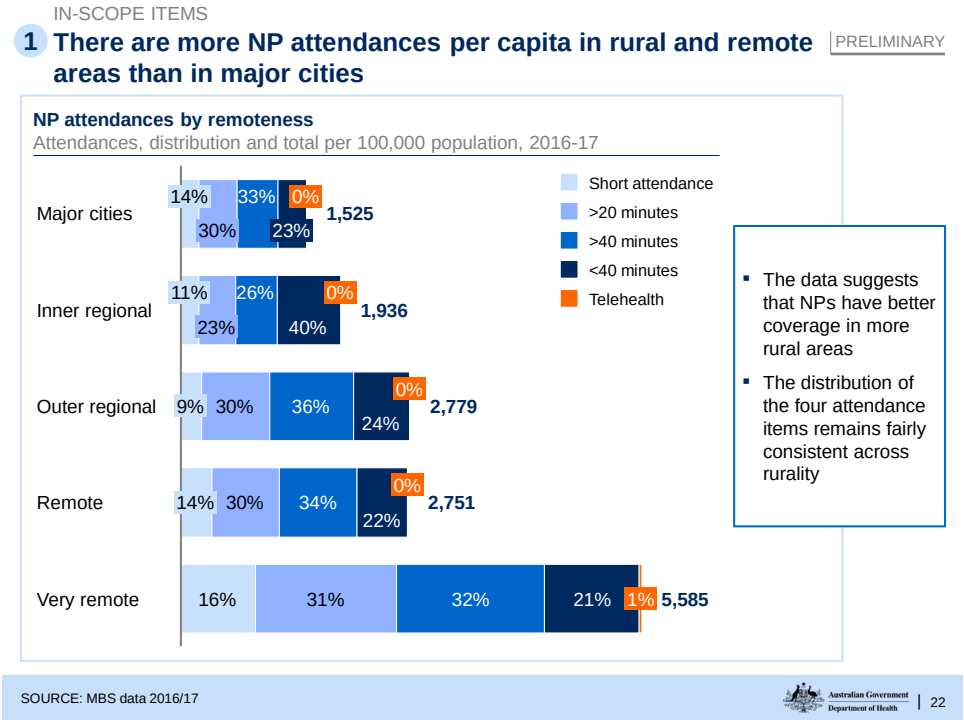
- Financial sustainability has been identified as a major limitation for NP models of care in private practice settings, particularly when relying on a bulk-billing fee model (21).
- The majority of NP models of care find it difficult to cover the cost of providing care without charging patients out-of-pocket fees. This is counter-intuitive for NPs who are working to provide services to underserved and marginalised populations, and unnecessarily burdensome for the communities they serve. The combination of low MBS rebates and low out-of-pocket fees makes it difficult for most NP models of care to cover their costs, creating a disincentive for any employer wishing to engage an NP, such as an Aboriginal Medical Service (Figure 27 – next page).
- In a mixed-methods evaluation of NP models in aged care, a key challenge was the financial sustainability of private practice NP models due to the low MBS schedule fee assigned to NP professional attendance items. Thirty per cent of NP-led services ceased to operate due to financial non-viability (3).

Figure 27: NPRG – Bulk-billing and out-of-pocket rates



- Significantly increasing rebates for NP professional attendance items will improve patients' ability to access NP services and, in turn, improve their care provider choices.
- This recommendation will improve NPs' ability to cover the costs of care provision, leading to a more financially viable model that allows them to provide services in the primary care setting, including to underserved and marginalised populations such as Aboriginal and/or Torres Strait Islander peoples, rural and remote populations, the homeless and aged patients. It would also support the rate of growth of this provider group.
- This recommendation may particularly improve rural and remote patients' access to and choice of primary care provider. MBS data shows that NPs provide a relatively high percentage of MBS services in rural and remote areas (Figure 28).

Figure 28: NPRG – NP attendances by remoteness area



- This recommendation will also improve equity within the MBS fee structure, aligning NP rebates more closely with those for other practitioners with similar qualifications, expertise and experience.
- NPs receive half the per-minute rate of clinical psychologists, despite comparable levels of education (master's level) and comparable advanced practice experience requirements. The per-minute rate for a clinical psychologist providing a 50-minute session is $2.49, compared to $1.24 a minute for a 40-minute attendance by an NP (assuming the minimum appointment time for each provider; MBS, 2018).
- The NP per-minute attendance rebate rate is also less than half of the rebate rate for GPs for a 40-minute attendance, despite often undertaking similar activities during professional attendances, with evidence to suggest comparable outcomes (22; 23).
- The NPRG recognises that this recommendation will only partially solve the issue of limited access to NP care. However, it is a vitally important component. Other recommendations in the report address additional barriers to access.

NPRG Recommendation 4 – Not endorsed for Government consideration

The Taskforce agrees this recommendation is better placed for submission to MSAC than for consideration through the MBS Review process.

Recommendation 5 - Longer nurse practitioner attendances to support the delivery of complex and comprehensive care

The NPRG recommends creating a new MBS item for longer NP attendances to support the delivery of complex and comprehensive care, with the proposed item descriptor as follows:

New item 822AA

Professional attendance by a participating nurse practitioner, lasting at least 60 minutes.

Rationale 5

This recommendation focuses on ensuring that attendance items reflect best practice and enable the provision of high-quality care to underserved populations. It is based on the following:

- The current time-tiered items for NP attendances do not reflect best practice. A range of care often needs to be provided in attendances lasting more than 60 minutes. For example:
    - Palliative care: These attendances often last for at least an hour due to the complexity of the care provided, which cannot be postponed or broken down into multiple shorter attendances. This can include a combination of pain and symptom management, psychosocial support, prescribing or adjusting multiple medications, referral to other health professionals and some procedural activities (such as insertion of urinary catheters).
    - Health care services for Aboriginal and Torres Strait Islander peoples: Many Aboriginal and/or Torres Strait Islander peoples have more than one chronic disease. Monitoring activities, engaging in a culturally safe way (which guides the location of the attendance, and the additional family, kin and community involved) and providing education on treatment and management, taking language and literacy difficulties into account, can be time-consuming to achieve the best outcomes for the patient.
    - Care for patients with dementia: Patients with dementia have cognitive impairments that make clinical assessment, shared care planning and procedural care more complicated. Longer consultation times are needed to deliver effective, best-practice care. This is relevant not just for formal cognitive screening/testing, but also for the more routine primary care attendances.
    - Specialist wound care: Consultations frequently take 60 minutes or longer to undertake various chronic wound assessment/treatments, including ankle-brachial pressure index measurement, chronic wound debridement and effective patient education.
    - Diabetes care: A specialist diabetes NP would require over 60 minutes with a patient to download and interpret data from a continuous blood glucose monitor then initiate treatment changes, including patient education. Similarly, starting a patient on an insulin pump routinely takes more than one hour.
- The length of attendances is affected by several factors, including patient age and socioeconomic status. Longer attendances are also an inherent consequence of the increasing burden of chronic disease (24).
- The cost of providing longer attendances is difficult for NPs to meet without charging high out-of-pocket costs or spreading care over multiple, shorter visits. This means that while there is a need for these services, patients are unable to access them.
- The patient rebate for an attendance of at least 40 minutes (item 82215) is already too low to be financially viable. This item cannot sustainably cover an attendance of over 60 minutes.

NPRG Recommendation 5 – Not endorsed

See overarching advice on scope of practice for nurse practitioners.

Recommendation 6 – Enable patients to access MBS rebates for after-hours or emergency care provided by nurse practitioners to facilitate care provided in the most appropriate settings and in a timely manner

The NPRG recommends:

a. enabling patients to access MBS rebates for after-hours or emergency care provided by NPs,

b. modifying MBS items that support patient access to emergency and after-hours assessment and treatment by vocationally qualified GPs and GP registrars to include care provided by NPs, examples of item numbers that should be revised include:

   (i) items 761–769 for professional attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies)

   (ii) items 772–789 for professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, and

   (iii) items 585–600 for urgent attendance after hours,

   and

c. applying the restrictions, controls and requirements that were introduced to MBS emergency and after-hours care in March 2018.

Rationale 6

This recommendation focuses on ensuring that timely, high-quality care is available to patients in the right location at the right time. It is based on the following:

- The MBS acknowledges the need for after-hours and emergency care through the existence of items that reimburse this care when provided by medical practitioners.
- The NPRG feels that this recommendation would particularly benefit patients who require care but do not have access to readily available health practitioners after hours—for example, those in RACFs, hostels, or palliative or community nursing services.
- There are currently no MBS rebates for patients who receive emergency or after-hours assessment and care from an NP, even when the NP may be best placed to provide this care (e.g. for geographical reasons, or because of a pre-existing role in caring for the patient).
- This results in reduced access to timely, appropriate assessment and treatment. This could prevent patients from seeking the necessary care (leading to worsening health issues), or prompt them to seek care within emergency departments where their needs may be a lower priority.
- Enabling patients to access these rebates when an NP is providing care would have beneficial outcomes for patients. In particular, the NPRG believes this change would offer patients an alternative to seeking care at emergency departments, and would have a positive effect on:
  - Achieving the goals of the Closing the Gap strategy.
  - The quality of palliative and end-of-life care.

- Access to timely care for residents of RACFs.

NPRG Recommendation 6 – Not endorsed for Government consideration

The Taskforce agrees further research is required to determine the scope and value of the model proposed. There are also questions around whether this could be addressed through the existing State and Territory funded models when a practitioner is within scope, appropriately trained, and in the right location.

Recommendation 7 – Enable patients to access MBS rebates for nurse practitioner care received outside of a clinic setting

The NPRG recommends enabling patients to access MBS rebates for NP care received outside of a clinic setting by creating new items for NP professional attendances (items 822BB, 822CC, 822DD and 822EE) with the proposed descriptors (using an attendance of less than 20 minutes as an example) is as follows:

New items – Example descriptor

Professional attendance by a nurse practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management, for an attendance on one or more patients at one place on one occasion.

Note: The NPRG notes that these items could parallel the existing GP professional attendances for out-of-rooms visits.

Rationale 7

This recommendation focuses on ensuring that appropriate and sustainable primary care is available to all Australians in the right location at the right time. It is based on the following:

- Enabling rebates for care received in out-of-rooms or out-of-clinic settings would parallel the structure of GP professional attendance items.
- This structure would enable more precise records to be maintained (through MBS item number tracking) on how frequently NP services are provided in non-clinic settings.

NPRG Recommendation 7 – Not endorsed for Government consideration

The Taskforce agrees further research is required to determine the scope and value of the model proposed. There are also questions around whether this could be addressed through the existing State and Territory funded models when a practitioner is within scope, appropriately trained, and in the right location.

Addressing system inefficiencies caused by current MBS arrangements

Recommendation 8 – Remove the mandated legislated requirements for nurse practitioners to form collaborative arrangements

The NPRG recommends removing the mandated requirement for NPs to form collaborative arrangements, in accordance with the *National Health (Collaborative arrangements for NPs) Determination 2010*.

Rationale 8

This recommendation focuses on the provision of affordable, universal and high-value care for patients, particularly in underserved areas. It is based on the following:

- A collaborative arrangement is defined as an arrangement between an eligible NP and a specified medical officer that must provide for consultation, referral and transfer of care as clinically relevant (25).
- The NPRG noted that this recommendation has implications for NP participation in the PBS.
- Collaborative arrangements have become an impediment to growth of the NP role in improving access to quality care for all Australians. This was a key finding of the National Health and Hospitals Reform Commission (26). NPs have also reported that collaborative arrangements work against true collaboration (27; 28).
- Some of the reasons for this are:
    - Collaborative arrangements can be difficult to develop, particularly in rural and remote areas (27). The availability and accessibility of medical practitioners with whom an NP can establish the mandated collaborative arrangement—when this is the selected form of collaboration—remains a challenge in some rural and remote locations, reducing patient access to NP care.
      In addition, difficulty recruiting a medical practitioner to collaborate with (when that is the selected mechanism) and resistance to NP referrals has been reported by some NPs in primary care.
    - Requiring an NP to establish a collaborative agreement makes them dependent on the willingness and availability of medical practitioners to participate (when this is the selected form of arrangement), but there is no requirement for medical practitioners to do so.
    - Collaborative arrangements can affect perceptions of the autonomy of NPs as legitimate health care providers.
- The original reasons behind establishing collaborative arrangements, such as avoiding fragmented care (29; 30), do not justify the continued requirement for these arrangements.
    - Collaborative arrangements for NPs were introduced in 2010 via the *National Health (Collaborative arrangements for NPs) Determination 2010*, as a prerequisite to an NP providing health care services subsidised by the MBS (11). This was a ministerial determination made at the time of the legislative amendments to allow patient access to rebates through the MBS for NP services. Neither the presence nor the effectiveness of collaborative arrangements has been monitored by DoH or DHS since implementation of the determination in 2010.
    - Experience over the last 18 years shows that NPs effectively collaborate without formal agreements. Collaboration is already required formally within NPs' standards of practice.
    - Collaboration is ingrained in nursing philosophy and is represented in the NMBA standards for practice for both RNs and NPs. Both sets of standards are grounded in actual (as opposed to aspirational) practice and are evidence-based (31). To meet the standards of practice (against which nurses are audited), collaborative practice must occur. A separate mandated collaborative arrangement is not required.
    - There is no evidence to suggest that collaborative arrangements increase collaboration between NPs and medical practitioners.

- Collaborative arrangements are not required in comparable countries. For example, mandated collaborative arrangements are not required for NPs practicing in New Zealand.
- Medical practitioners do not face increased liability by working with NPs in the absence of collaborative arrangements. Conversely, collaborative arrangements may expose medical practitioners to increased liability (32).

- Nurses and midwives are the only health professionals required by law to establish an arrangement with a medical officer in order to participate in the MBS.

Case Study – Diagnostic Imaging 1

James practises as an NP in an urban homelessness clinic in the Australian Capital Territory (ACT). He is the sole health provider in a bulk-billing clinic and provides comprehensive primary health care services across the lifespan of clients.

A typical day requires James to assess, diagnose and manage long-term health conditions in his population, such as diabetes, depression, drug and alcohol dependence, and hypertension. James assesses and manages acute, minor illnesses and injuries such as upper respiratory tract and skin infections, sexually transmitted infections, musculoskeletal conditions and wounds. He provides a wide range of preventive health care services, including routine vaccinations and lifestyle modification interventions, such as smoking cessation counselling and nutrition advice.

James also cares for people with complex health requirements. However, he is frequently required to refer clients to a general practice, as current MBS rules do not enable him to initiate many common diagnostic imaging tests otherwise subsidised in primary health care, such as ultrasounds and X-rays. This causes frustration for clients whose care experience becomes fragmented. It also involves unnecessary duplication of services. Although the general practice is willing to see patients referred by James, the practice often does not have an appointment available for several days. Clients are frustrated because they know James is sometimes able to initiate an investigation, while at other times he needs to refer them to a general practice—a visit that may not always be bulk billed. As a result, clients attending the homelessness clinic often do not continue to seek treatment for their problems or end up attending the local public hospital emergency department to obtain imaging requests that could have been requested in James' homelessness clinic.

Case Study – Diagnostic Imaging 2

Susan is a primary healthcare NP who has a 15-minute appointment booked with a male university student that she has not seen before. The student is presenting for a sick certificate, as he has been unable to attend exams due to recurrent severe headaches. He had previously been seen by other practitioners in the clinic for similar headaches.

At first glance the student appears to be a fit and healthy 19-year-old. Susan conducts a comprehensive assessment and notes that the patient has hearing loss in his left ear and has a mild ptosis of his left eye. Concerned, Susan conducts a thorough review of his previous visits. On each occasion the patient was advised to take Panadol and given a medical certificate. However, on review of his record Susan notices the patient has several untranslated medical records imported into his file that were in French. Luckily Susan has a rudimentary understanding of French and becomes increasingly concerned when she discerns the patient was given a diagnosis of neurofibramatosis many years ago after having his hearing evaluated as a child in France.

Susan calls a local neurology team, as she is suspicious the patient may have progression of his disease due to the constellation of his symptoms. After discussing the case over the phone, the neurologist

identifies she would like to see the patient early the following week, but would like him to have an MRI performed prior to his appointment. Susan can request the MRI but the test will not be subsidised by the MBS if requested by a NP, resulting in significant out of pocket expenses for her patient. The patient doesn't feel comfortable going to another health provider that he doesn't know for an imaging request. Ultimately, the patient has his appointment with the neurologist, but didn't have an MRI to review at his appointment. This resulted in significant delays as the patient had to then be referred for the MRI and return to the specialist appointment, which eventually revealed progression of extensive schwannomas and bilateral acoustic neuromas.

NPRG Recommendation 8 – Not endorsed for Government consideration

The Taskforce has considered the arguments presented carefully but cannot support these recommendations as the risks of removing Collaborative Arrangements will impact patient safety. The Taskforce agrees Collaborative Arrangements are critically important, noting collaboration is an essential protection for both the patient (and unborn child), especially in rural and remote areas. Having a team providing patient care promotes minimal fragmentation of care by ensuring responsibility and accountability.

The Taskforce does not view Collaborative Arrangements as an administrative limitation, rather a process designed to promote a cooperative culture and underpin patient (and child) safety.

The Taskforce does, however, note the difficulties to date in achieving Collaborative Arrangements within the current framework, and agree that significant research needs to be done on how to address and streamline current administrative barriers, without removing the existing requirement.

See Additional Taskforce Recommendation on Collaborative Arrangements.

Recommendation 9 - Remove current restrictions on MBS-rebated diagnostic imaging investigations when requested by nurse practitioners working within their scope of practice

The NPRG recommends:

a. removing current restrictions on diagnostic imaging investigations subsidised under the MBS when requested by NPs working within their scope of practice, and

b. in particular, restrictions should be removed from the following items, which serve as exemplars:

(i) Ultrasound investigations.

- General: items 55028, 55032, 55038, 55048, 55054 and 55065.
- Cardiac: items 55113, 55114, 55115, 55116 and 55117.
- Vascular: items 55238, 55244, 55246, 55248, 55252, 55274, 55276, 55278 and 55292.
- Obstetrics/gynaecology: items 55700, 55703, 55704, 55706, 55707 and 55718.

(ii) Diagnostic radiology investigations.

- Head: items 57901, 57902, 57903, 57912, 57915, 57921, 57924, 57927, 57933, 57945, 57960, 57963, 57966 and 57969.
- Spine: items 58100, 58103, 58106, 58108, 58109, 58112, 58115, 58120 and 58121.
- Alimentary tract and biliary system: items 58903 and 58909.

- Localisation of foreign body: item 59103.
- Breasts: items 59300 and 59303.
- Tomography: item 60100.
- Fluoroscopic exam and report: items 60506 and 60509.

(iii) Computerised tomography imaging examinations.

- items 56001, 56007, 56016, 56022, 56030, 56101, 56107, 56220, 56223, 56233, 56301, 56307, 56409, 56412, 56501, 56507, 56619, 56801, 56807, 57007, 57341, 57350, 57360 and 57362.

(iv) Magnetic resonance imaging examinations.

- items 63551, 63554 and 63560.

(v) Nuclear medicine imaging items.

- items 61307, 61348, 61421, 61425, 61449, 61473 and 61505.

(vi) Other Diagnostic Procedures and Investigations

- items 12306, 12312, 12315, 12321, 12320 and 12322

Rationale 9

This recommendation focuses on reducing fragmentation in care. It is based on the following:

- The NPRG notes that this recommendation is not about increasing the NP scope of practice, as NPs can request any diagnostic investigation within their individual scope of practice outside the MBS. NPs are a safe and effective health workforce, with a demonstrated ability to adapt and respond to gaps in health service delivery, traverse the boundaries of health settings, and provide affordable, accessible health care for marginalised and vulnerable populations in primary and community health care.
- Enabling patients to access an MBS rebate for diagnostic imaging investigations requested by an NP would have positive outcomes for patients. Currently, patients only receive MBS rebates for a limited number of diagnostic imaging investigations requested by an NP. In the event that a rebate is not available for a diagnostic imaging service when requested by an NP, patients must either:
    - Be referred to a medical practitioner (where available) in order to receive the rebate for diagnostic imaging services. This creates barriers to the provision of timely and appropriate health care and results in the costly duplication of services, delays and fragmented episodes of care (27; 21).
    - Forego the MBS rebate to which they are entitled and pay the full, unsubsidised cost for the diagnostic imaging service. This is an inequitable transfer of cost to the patient, who would not be required to pay the full cost if the service was provided by a GP.
    - Decide not to undertake diagnostic testing (for example, if they are not able to afford the required imaging services). This may affect patient outcomes.
- This recommendation will enable NP models of care to provide more timely and efficient health care by enabling them to work to their full potential. It will also reduce the challenges of fragmentation and duplication of care, inequitable cost burdens, and the risks of increased morbidity and/or mortality outlined above. This is particularly true in areas where NP models have been established to address existing health workforce and service delivery shortages. Allowing NPs to work to their full potential is associated with higher supply in rural and primary care health professional areas (33).

- The recommendation may also assist with the development and implementation of NP models of care that align with the original intent of the role by:
    - Supporting the provision of flexible and responsive care that adapts to identified needs in marginalised and vulnerable communities.
    - Supporting NP workforce sustainability.
    - Better enabling NPs to align their practice with supporting evidence-based guidelines in clinical care.
    - Promoting timely and effective referrals to medical specialists and consultant physicians, resulting in improved patient access to informed, specialised medical care.

NPRG Recommendation 9 – Not endorsed for Government consideration

See overarching advice on scope of practice for nurse practitioners.

Additionally, the Taskforce agrees there is a risk to patient safety if the NP is not trained appropriately to interpret results and respond appropriately. The Taskforce also notes that additional tests being sought would require further access and governance processes that have not been suitably considered.

Recommendation 10 – Enable patients to access MBS rebates for procedures performed by an nurse practitioner working within their scope of practice

The NPRG recommends:

a. enabling patients to access MBS rebates for procedures performed by an NP by changing the restrictions for diagnostic and therapeutic procedures that can be performed by GPs to also include NPs who are working within their scope of practice, and

b. in particular, NPs need to be able to request and/or perform the following:

(i) Category 2 – diagnostic procedures and investigations.

- item 11506: Spirometry – measurement of respiratory function before and after inhalation of bronchodilator.
- item 11700: 12-lead electrocardiography, tracing and report.
- item 11610: Measurement of ankle-brachial indices and arterial waveforms
- item 73811: Mantoux test.
- item 73839: Quantitation of HbA1c performed for diagnosis of diabetes in asymptomatic patient at high risk.
- item 73840: Quantitation of glycosylated haemoglobin performed in the management of established diabetes.
- item 73844: Quantitation of urinary microalbumin as determined by urine albumin excretion on a timed overnight urine sample or urine albumin/creatinine ratio as determined on a first morning urine sample in the management of established diabetes

(ii) Category 3 – therapeutic procedures.

- item 14206: Implanon insertion (hormone or living tissue implantation by cannula).

- item 30062: Implanon removal including suturing.
- item 30003: Dressing of localised burn.
- item 30071: Diagnostic biopsy skin or mucous membrane.
- item 30216: Aspiration of haematoma.
- item 41500: Foreign body ear – removal of (by means other than simple syringing).
- item 30023: Deep or extensively contaminated wound including suturing under anaesthesia.
- item 30026: Suture < 7cm superficial not face.
- item 30029: Suture < 7cm deep not face.
- item 30032: Suture < 7cm deep face.
- item 30038: Suture >7cm superficial not face.
- item 30042: Suture >7cm deep not face
- item 30052: Suture eyelid/nose/ear.
- item 30061: Foreign body superficial – Removal of (inc. Cornea/Sclera).
- item 30064: Foreign Body Subcutaneous – Removal of.
- 30071 Diagnostic Biopsy skin or mucous membrane.
- item 30219: Haematoma, Furuncle, Abscess, and Lesion – Incision with drainage of.
- items 31356–31376: Removal of skin lesions.
- item 41500: Foreign body ear – removal of by means other than simple syringing.
- item 41659: Foreign body nose – removal of by means other than simple probing.
- item 42644: Foreign body Cornea/Sclera – removal of imbedded.
- item 47915: Ingrowing nail of toe, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed.
- item 35503: Insertion of Intra-uterine contraceptive device (IUD).
- item 36800: Catheterisation of the bladder.

Rationale 10

This recommendation focuses on reducing fragmentation in care. It is based on the following:

- This change should expand (rather than replace) the current list of procedures for which rebates already exist for NP-performed procedures.
- Under current MBS rules, rebates for most diagnostic and therapeutic procedures are not available to patients when those procedures are performed by an NP.
- NPs perform a variety of diagnostic and therapeutic procedures across all care settings, in accordance with their scope of practice.

- As with diagnostic imaging referrals, the lack of MBS rebates for diagnostic and therapeutic procedures performed by NPs can increase out-of-pocket costs for patients, perpetuate inefficiencies through duplication of care, and blur care accountability. It also imposes an unnecessary limitation on the NP workforce.
- Currently, the person receiving a procedure performed by an NP is required to pay the full cost of a procedure (without an MBS rebate), in addition to the professional attendance fee.
- Duplication, delays and inefficiencies can be created when a patient is referred to a medical practitioner for a procedure in order to be able to access the MBS rebate to which they are entitled. This practice also blurs accountability for care and limits the role of NPs as autonomous and independent health providers.
- Research in primary care has found that duplication of services (attributed to the inability of NPs to perform or request diagnostic and therapeutic items subsidised under the MBS) interrupts workflow and delays patient care (21). For example, patients may be referred to other services, including emergency departments, for some procedures because there is no adequate MBS rebate to support patients accessing this care from an NP.
- The ability to facilitate access to MBS rebates for diagnostic and therapeutic procedures performed by NPs will support more affordable, equitable and accessible care in primary health, community, rural and remote, and residential aged care settings. Vulnerable health patients are particularly affected by the lack of MBS rebates for care provided by NPs (18).
- This recommendation will also increase the financial viability of NP services by better recognising the broad range of services that NPs are able to provide. This will enable more equitable and accessible health services (18).
- Access to MBS rebates for items performed by NPs may be cost-neutral because duplication of services would be eliminated. Access to health care for the most vulnerable patients would also be improved.
- Other benefits of this recommendation may include increased professional colleague and patient satisfaction with the type of care provided, a decrease in patient waiting times due to improved access, and increased productivity as NPs are able to contribute to the overall provision of health care services (21; 22).

NPRG Recommendation 10 – Not endorsed for Government consideration

See overarching advice on scope of practice for nurse practitioners.

Improving patient access to telehealth services

The role of telehealth

The NPRG acknowledged that the role of non-face-to-face communications is an increasingly important one in health services and patient care. For NPs acting as a primary care giver, as well as those in more specialised roles, telehealth offers an opportunity to provide high-value care to patients who may not be able to see their health provider in person.

The NPRG noted that the long-term solution for telehealth support, as part of a comprehensive suite of health services, may not be through a fee-for-service MBS. However, it felt it was important to include actionable, shorter-term recommendations for specific items, both existing and new, that could address the current service gap in telehealth.

The NPRG considered various restrictions on proposed telehealth items in order to ensure that they are not abused, and that telehealth is only used when it is a mechanism for providing high-value care to a patient. These included:

- Rurality: Ensure that patients who use telehealth services are not easily able to access a relevant health provider for a face-to-face consultation.
- Usual practitioner: Ensure that patients receive telehealth support from a provider who is focused on the patient and is providing telehealth support because it is the best medium available (rather than being focused on telehealth and providing a service to a patient simply because the option is available).
- Follow-up care: Ensure that patients only receive telehealth support when the attendance is in relation to a clinical issue already discussed at a face-to-face consultation.
- Patient-side support: Ensure that, where relevant, an appropriate practitioner is physically in attendance with the patient during their telehealth consultation.

Ultimately, the NPRG decided against identifying the specific conditions associated with these dimensions, as several exceptions could be found for each of them. Some suggestions are included with each of the recommendations below, as a starting place for implementation.

The advantages of telehealth

For patients, the main benefit of using telehealth services is increased access to health care, with non-inferior outcomes, where clinically appropriate. Evidence for this includes the following:

- Surveys have consistently found high patient satisfaction with telehealth consultations (34; 35; 36).
- Compared to usual care, a range of telehealth interventions have been found to produce at least equivalent outcomes in the management of asthma (37; 38), blood pressure (39) and depression, and in overall quality of life (40).

A systematic literature review of telehealth services in rural and remote Australia reviewed models of care and factors influencing success and sustainability. Funding for general medical and other practitioners for the provision of telehealth services is limited or non-existent (41).

In a study in the United States, the transaction costs of in-clinic consultations and telehealth presentations were compared for chronic pain management provided by community-based providers including NPs, primary care physicians and physician assistants. Although similar in terms of cost, telehealth consultations demonstrated preliminary evidence for improved patient satisfaction with treatment, improved provider satisfaction with the consultation process, reduced wait times and reduced health care utilisation (42).

Recommendation 11 - Add GPs as eligible participants in nurse practitioner patient-side telehealth services

The NPRG recommends:

a. adding GPs as eligible participants in NP patient-side telehealth services (items 82220, 82221 and 82222)

b. including all Aboriginal and/or Torres Strait Islander peoples, not only patients of Aboriginal Medical Services or ACCHS with a 19(2) exemption, and

c. amending the item descriptors along the lines of the following example:

item 82220 – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP that requires the provision of clinical support to a patient who:

a. is participating in a video consultation with a specialist, consultant physician, or GP, and

b. is not an admitted patient of a hospital, and

c. is located:

(i) both:

- within a telehealth eligible area, and
- at the time of the attendance - at least 15 kms by road from the specialist, consultant physician or GP mentioned in paragraph (a)

or

(ii) in Australia if the patient is of Aboriginal or Torres Strait Islander descent.

Note: The NPRG recognises that this item would require GPs to have access to reimbursement for telehealth service provision, whether through an MBS item number or a different funding model.

Rationale 11

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Telehealth services provide high-quality care options for Australians.
- GP-to-patient telehealth items with an NP on the patient side would help to fill current access gaps and allow for the provision of clinically effective, high-value services to patients, including:
    - GPs as eligible telehealth providers will increase patient access to primary care, particularly in remote areas where such access is more limited. NPs are well placed to support these telehealth services due to their relatively higher presence in remote areas (compared to GPs).
    - GPs would also decrease wait times to see the GP (by enabling consultation at the time of need), minimise cost for the patient (by mitigating the need to travel to the GP) and enhance buy-in from remote sites (43).
    - Limiting the video telehealth attendance to clinical support with a specialist or consultant physician restricts patient access to health care providers when an NP is seeking consultation with a patient and a GP. Often it is more appropriate, cost-effective and efficient to consult with a collaborating GP, rather than a specialist or consultant physician, especially for people who are geographically marginalised (living in Modified Monash Model areas 4 to 7), people in aged care and people in palliative care who are being managed at home.
- The current structure of telehealth items limits NP uptake. A survey of 73 NPs who work in primary care and access the MBS indicated that only 12 per cent had ever used telehealth items. It identified the requirement to have a specialist or consultant present as the main reason for non-use of telehealth items (44). MBS data showed that there were only 1,033 telehealth rebate claims in 2016/17 (less than 0.3 per cent of NP services for the year).

- GP telehealth items enable collaborative relationships between NPs and GPs, as NPs support from the patient side to facilitate care.
- The RACGP has developed clinical guidelines to enable the implementation of video consultations in general practice. These guidelines provide valuable insight and strategies to mitigate risk (45).
- Access to telehealth items for Aboriginal and/or Torres Strait Islander peoples in all regions, from urban to remote, may help to improve uptake of services where low cultural safety limits their ability to access services.

NPRG Recommendation 11 – Referred

This recommendation was referred to the Telehealth Working Group.

Recommendation 12 - Add patients in community aged care settings to residential aged care telehealth items

The NPRG recommends adding patients in community aged care settings to residential aged care telehealth items (82223, 82224 and 82225) with the proposed descriptors as follows:

> *"… patients in receipt of, or assessed as eligible for, Government-funded Home Care Packages."*

Rationale 12

This recommendation focuses on increasing access to, and use of, telehealth services for patients who face difficulties accessing their primary health provider despite living in urban areas. It is based on the following:

- NPs often provide services to older people living in RACFs and those who are still living at home but in receipt of (or assessed as eligible for) Government-funded HCP.
- Patients receiving funding through the HCP program have similar levels of frailty and dependence to those living in residential aged care. Despite living in urban areas, they often have mobility and illness limitations, which impede their ability to access medical and NP services.

NPRG Recommendation 12 – Referred

This recommendation was referred to the Telehealth Working Group.

Recommendation 13 – Create new MBS items for direct nurse practitioner-to-patient telehealth consultations

The NPRG recommends:

a. creating new MBS items for direct NP-to-patient telehealth consultations (items 8222A, 8222B and 8222C) with the proposed descriptors (using item 8222A as an example):

New item 8222A – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP practising in MMM 2-7 that requires the provision of clinical support to a patient who:

a. is participating in a video consultation with the nurse practitioner, and

b. is not an admitted patient, and

c. is located:

(i) both:

- within an MMM 2-7 area, and
- at the time of the attendance - at least 35 kilometres from the nurse practitioner's location (a)

or

(ii) in Australia if the patient is of Aboriginal or Torres Strait Islander descent.

b. these items should parallel the time-tiers of existing patient-side items (i.e. less than 20 minutes, at least 20 minutes and at least 40 minutes), and

c. there should be no requirement for any particular health service professional to be patient-side.

Rationale 13

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Telehealth services are high-quality care options for Australians.
- Telehealth sessions between an NP and a patient will improve access to timely care, reduce fragmentation, reduce or avoid the need for patients to be transferred to access required care, and allow for clinically effective, high-value services for patients. For example:
  - Telehealth services could be used for managing a patient who may already have medications/dressing available, to triage for the need for a physical consult, and/or to follow up on a face-to-face consult.
  - Telehealth services can increase access for patients in isolated areas. For example, a patient based at a cattle station will require access to care for an initial contact, for urgent or emergent care, or for follow-up care. If provided face to face, patients would face barriers including cost, travel and time away from community.
  - Telehealth consultations can help improve access for patients with physical disabilities (who may find it difficult to get to an NP's office) and for patients with intellectual disabilities (who may not respond well to unfamiliar surroundings).
  - Telehealth consultations can support NPs in providing primary care across the aged care sector. Enabling aged care nurses to access the support of NPs, particularly after hours, would further enhance NPs' contribution to improving health outcomes and avoid deterioration in health status for older people.
- The NPRG acknowledges that there could be benefit in a patient-side attendance by an RN, an Aboriginal and Torres Strait Islander health worker or health practitioner, an allied health professional, an enrolled nurse, or other health care providers.

NPRG Recommendation 13 – Referred

This recommendation was referred to the Telehealth Working Group.

Recommendation 14 - Allow telehealth consultations to take place via telephone where clinically appropriate

The NPRG recommends allowing telehealth consultations to take place via telephone where clinically appropriate (i.e. without requiring a video connection) (items 82220, 82221, 82222, 82223, 82224, 82225, 8222A, 8222B and 8222C).

Rationale 14

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Requiring video connections between patient and practitioner has been shown to limit patient access to telehealth services (46; 47).
- Patients may be unable to undertake video communication due to:
    - Poor internet connections, often due to remoteness.
    - Lack of access to necessary technology.
    - Lack of understanding of or comfort with technology.
- Telephone communication for telehealth services offers non-inferior outcomes, where clinically appropriate (47; 48).

NPRG Recommendation 14 – Referred

This recommendation was referred to the Telehealth Working Group.

4.6.4 Nurse Practitioner Reference Group Stakeholder Impact Statement

Both consumers and NPs are expected to benefit from the recommendations in this report. In making its recommendations, the NPRG's primary focus was ensuring consumer access to high-quality primary care services. The NPRG also considered the effect of its recommendations on NPs and other health professionals to ensure that they were fair and reasonable.

Patients will benefit from the NPRG's recommendations through improved access to continuity of primary care models and higher quality clinical services, particularly in aged care, chronic disease management, and rural and remote areas. This includes:

- **Affordable, accessible primary care of choice.**
    - Significantly increasing patient rebates for services provided by NPs will improve patient access to primary care, lower costs for consumers, enable patient choice and establish access where no care options exist. This will be particularly beneficial for underserved and marginalised populations such as Aboriginal and/or Torres Strait Islander communities, the homeless and socially isolated people.
    - Consumers want real choice in their primary health care. This is not currently available consistently across Australia. In some rural and remote areas, there are few health service delivery options available.

- Aboriginal and/or Torres Strait Islander peoples have expressed the importance of receiving primary care "on country" to feel culturally safe and to maximise their health outcomes. Inadequate MBS rebates to support access to NP services on country means that patients must often travel to seek primary care and/or experience unreasonable delays in receiving care. This can result in further deterioration of their health and/or an inability to seek the care they require. The poor outcomes that result for Aboriginal and/or Torres Strait Islander peoples who face barriers to care are preventable and could be improved by broadening access to NP services, particularly for people with chronic illness and disease.
- Recommended changes to telehealth services seek to improve access to care by broadening the types of providers who are eligible to participate in telehealth, as well as the modes of communication that are used. These changes will provide increased opportunity for patients to receive affordable, high-value and best-practice primary health care from the practitioner of their choice.
- These changes will also improve the care experience for patients in rural and remote regions, who will be able to engage and develop a relationship with their chosen primary health care provider without travelling long distances.
- There is limited subsidised access to health care in high-priority areas that are often serviced by NPs, including aged care, mental health, palliative care and chronic disease management. This is due to the restricted number of MBS rebates available to patients when NPs provide or initiate services. Improving support for NP services through the MBS for people living in residential care will reduce unnecessary deteriorations in health status, which often occur for older Australians who experience delays in receiving care. In palliative care, changes to support NP services will provide a foundation to support improved end-of-life care and make a meaningful difference to quality of life for many Australians.
- Significantly increasing the MBS rebate for NP attendances and providing MBS rebates for NP home visits and outreach work will improve access for vulnerable patients who need timely, affordable care in non-traditional environments. Such care is often provided opportunistically, rather than through traditional visits to a general practice or consulting room. Provision of such care within the community will reduce unnecessary costs, fear and disruption for consumers, as well as any unintended consequences of emergency or hospital care.
- Allowing patients who live in RACFs and those who receive Commonwealth-funded community aged care in the home in all areas (Modified Monash Model areas 1–7) to access rebates for telehealth services will mean that they can be treated in their own home without the disruption, confusion, discomfort or distress of unnecessary transfer to hospital.

- **High-value, best-practice health care.**
  - Improving patient access to MBS items for services provided and initiated by NPs will maximise choice, reduce fragmentation and duplication for consumers, and reduce current inefficiencies and improve cost-effectiveness across Australia's health system.
  - The recommendations in this report support the provision of high-quality care to patients by removing artificial barriers to real collaboration between service providers, and by recognising the value of NP attendances (which last at least 60 minutes in some circumstances).
  - The recommendations will also enhance continuity of care provided by NPs, who provide high-value care to patients, as highlighted by national and international research cited throughout the report. Enabling consumers to access appropriate MBS rebates for NP services will limit the unnecessary duplication of services, fragmentation of care, and other inefficiencies currently experienced by NP patients within existing MBS arrangements.

- Building trust with a known primary care professional reduces patients' apprehension and increases their confidence in the care provided. Patients will benefit from the availability of MBS rebates for health assessments and chronic care and team care arrangements undertaken by an NP, as well as case conferences coordinated by an NP, because they will no longer have to attend multiple appointments with another practitioner, who may not be their primary care provider, in order to receive the rebates to which they would otherwise be entitled.
- Similarly, being able to access MBS rebates for diagnostic imaging and procedures performed by NPs will assist patients in avoiding the inefficiencies, cost and inconvenience of visiting additional providers.

The NPRG's recommendations will benefit NPs by enshrining a more accurate representation of their scope of practice in the MBS, and through increased financial recognition of the care they provide. More broadly, NPs will benefit from increased choice in working models as NP care becomes a financially and structurally viable option.

Consumers, NPs and the Australian health care system will benefit from overall increased investment in NP continuity of primary care, as recommended in this report. These benefits will accrue from high-quality, cost-effective health outcomes that benefit families and the community.

4.7 Participating Midwives Reference Group

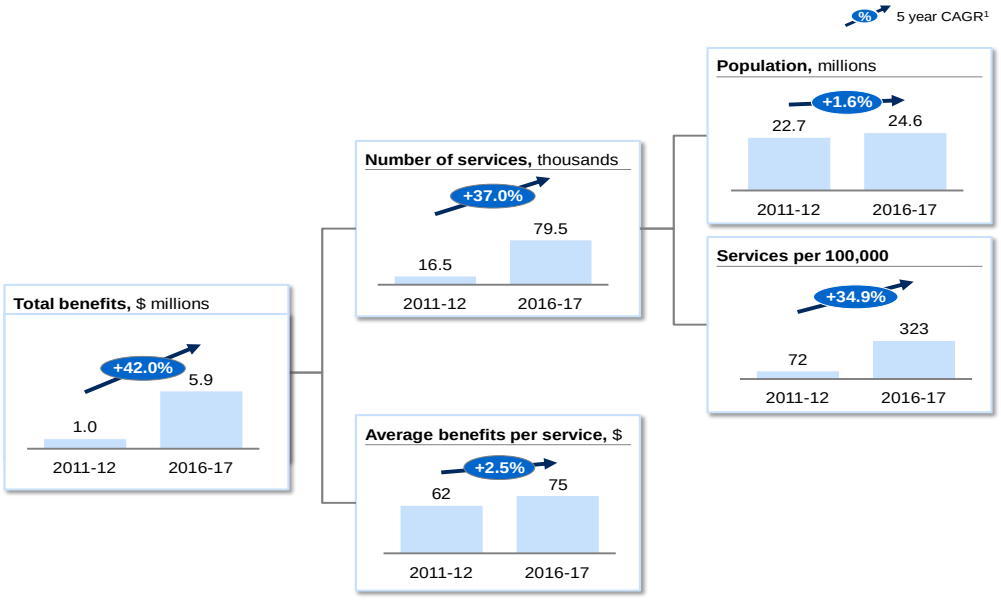
4.7.1 Participating Midwives Reference Group's Areas of Responsibility

A list of all items reviewed by the PMRG can be found at Appendix B.

items for participating midwives were added to the MBS in 2010. These MBS items are provided by participating midwives, i.e. midwives endorsed by the NMBA who work in a collaborative arrangement as defined in legislation. The PMRG was asked to review the 12 items in MBS group *M13: Midwifery Services (82100–82152)*.

These 12 items cover antenatal, intrapartum and postnatal (up to seven weeks post-birth) periods of care. In 2016/17, approximately 79,500 services were claimed and $5.9 million was paid in benefits under these items. Over the past five years, service volumes for midwifery MBS items have increased by 37 per cent (compounded annually), and the cost of benefits has increased by 2.5 per cent (compounded annually) (Figure 29).

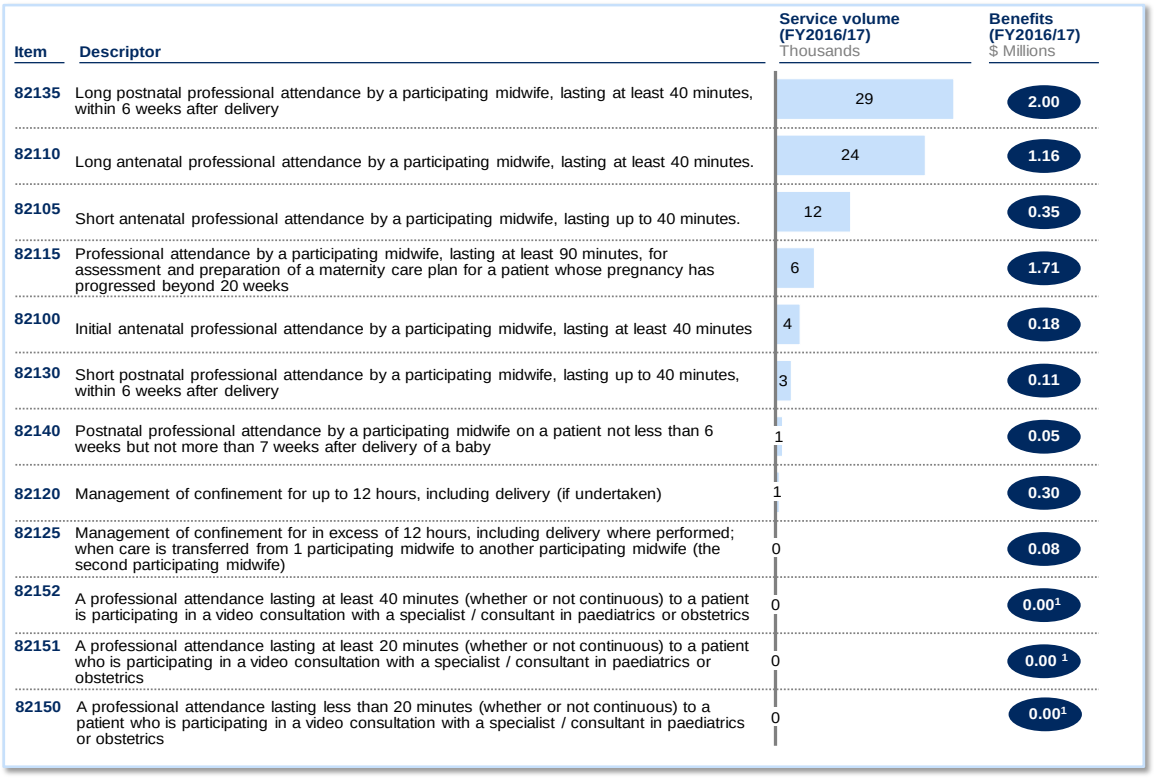
Figure 29: PMRG – Drivers of benefit growth, 2011/12 to 2016/17



Source: MBS Data 2011/12 – 2016/17

In 2016/17, long antenatal and postnatal professional attendances lasting at least 40 minutes accounted for approximately 67 per cent of service volume. Long postnatal professional attendances had the highest service volume, at 28,844 services (Figure 30).

Figure 30: PMRG – Midwifery item groups ordered by service volume



Item	Descriptor	Service volume (FY2016/17) Thousands	Benefits (FY2016/17) $ Millions
82135	Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery	29	2.00
82110	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	24	1.16
82105	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.	12	0.35
82115	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks	6	1.71
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes	4	0.18
82130	Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery	3	0.11
82140	Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby	1	0.05
82120	Management of confinement for up to 12 hours, including delivery (if undertaken)	1	0.30
82125	Management of confinement for in excess of 12 hours, including delivery where performed; when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)	0	0.08
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	0	0.00[1]
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	0	0.00 [1]
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	0	0.00[1]

Source: MBS Data 2011/12 – 2016/17

4.7.2 Participating Midwives Reference Group's Review Approach

The PMRG completed its work across four full-day meetings and a number of teleconferences, during which it developed the recommendations and rationales outlined in this report.

The review drew on various types of MBS data, including data on:

- utilisation of items (services, benefits, patients, providers and growth rates),
- service provision (type of provider, geography of service provision),
- patients (demographics and services per patient),
- co-claiming or episodes of services (same-day claiming and claiming with specific items over time), and
- additional provider and patient-level data, when required.

The review also drew on information available in relevant national and professional guidelines, medical literature, and other high-quality sources of evidence, all of which are referenced in the report.

The PMRG reviewed and considered hundreds of relevant stakeholder submissions to the MBS Review in making its recommendations.

Main themes

Throughout the review process, several consistent themes became apparent to the PMRG, based on extensive group discussions, data and literature reviews, consumer feedback, and stakeholder representation. These themes are relevant not just to the recommendations contained in this report, but

also to the current challenges and future directions of maternity care in Australia. The four themes identified were:

1. **There is overwhelming evidence that midwifery continuity of care results in outstanding clinical, financial and consumer satisfaction outcomes that benefit families and the community.**

Optimal clinical outcomes:

- Throughout the developed world, normal birth rates are decreasing and interventions are increasing, yet there is no improvement in maternal and neonatal mortality as a result. Government plans such as "Towards Normal Birth" (NSW Health) and WHO recommendations highlight the need to reduce unnecessary interventions (1; 2; 3; 4). Over the past 10 years, midwifery continuity of care models internationally and in Australia have continually demonstrated outstanding clinical outcomes, including (5;6):
    - Normal birth rates above 80 per cent.
    - Decreased intervention rates compared to other maternity care models.
    - Improved outcomes for mothers and infants, including reduced preterm birth and foetal and neonatal death.
    - No associated increases in maternal or neonatal mortality.
- Importantly, midwifery continuity of care has been shown to mitigate the effects of high levels of stress on postnatal maternal mental health (6).
- The PMRG agrees that any strategies that promote access to this model of care for women and families should be supported.

Fiscally advantageous model:

- Midwifery continuity of care avoids many high-cost interventions and improves clinical outcomes, leading to lower health costs (for example, increased breastfeeding rates, improved mental health outcomes and improved immunity) (7). The M@NGO study compared the cost of continuity of midwifery care with standard maternity care for women at all risk levels in Australia. The study demonstrated that the total cost of care per woman was $566.74 (95 per cent) less for midwifery continuity of care than for standard maternity care. When infant costs were included, this increased to $838.17 per mother/infant pair (8).
- The current national efficient price (2018/19) for an uncomplicated normal birth (O60C) is $4082 (wt. 0.8145). This price is for the in-patient component of labour, birth and postnatal care only (excludes antenatal care and postnatal home visits) (9). Although states and territories are funded at this amount for the care they provide to women, the MBS schedule fee for the same care provided by a private midwife is $753.30, despite the midwifery model resulting in enhanced outcomes compared to most standard hospital models.
- The PMRG contends that increasing access to midwifery continuity of care would decrease the overall cost of maternity care by redistributing funding.

Consumer satisfaction and demand:

- The consumer voice for maternity care in Australia is strong, persistent and consistent in its messaging. All reviews of maternity services conducted over the last two decades indicate that consumers want choice in their care and access to continuity of care.

- The most recent consumer feedback comes from the first round of consultation on the National Strategic Approach to Maternity Services. This clearly indicates a demand for midwifery continuity of care, and that access is limited through the public hospital system for women with pregnancies at all levels of risk. Consultation feedback also indicated the need to make changes to MBS midwifery items to improve access for women (10; 11).
- The 2009 Report of the Maternity Services Review (the Report) noted that consumer submissions demonstrated a clear preference for care by midwives, either in birthing centres or in the home setting. Overall, the Report recommended changes to improve choice and the availability of a range of models of maternity care for Australian mothers by supporting an expanded role for midwives (12).

2. Across Australia, less than 10 per cent of women can access continuity of midwifery care, despite strong demand (13)**.**

- Significant barriers currently prevent consumer access to MBS-rebated midwifery continuity of care in Australia, despite the benefits associated with the model, including:
    - **Legislative barriers:** The implementation of MBS-rebated midwifery continuity of care has been limited by requirements for midwives to enter into collaborative arrangements, and by the lack of public hospitals offering "access agreements" to participating midwives to enable the admission of a woman to hospital under the continuing care of the midwife.
    - **Regulatory barriers:** Midwives are required to have amassed 5000 hours of direct clinical care in six years prior to obtaining an MBS provider number. This requirement, coupled with a requirement for postgraduate qualifications in prescribing and diagnostics (rather than recognition of undergraduate qualifications), has limited access for women to MBS-rebated midwives.
    - **Insurance barriers:** Complex insurance legislation requires midwives to be sole traders or directors of the company that employs them. This means that participating midwives are restricted from working in a midwifery practice unless they are the director. This limits women's access to midwives with appropriate insurance. In addition, there is no insurance product available for participating midwives attending homebirths, and no affordable insurance product for Aboriginal Community Controlled Health Organisations to employ midwives to provide intrapartum care.

3. "Bundled payment" funding models may more appropriately reflect the model and increase the uptake of midwifery continuity of care in Australia.

Bundled payments for health care have been implemented internationally, leading to improvements in quality of care (14; 15). The PMRG contends that the clearly delineated components of maternity care (antenatal, intrapartum, postnatal) make this model appropriate for further exploration. This funding model would also be simpler for consumers, as would a single rebate provided for their maternity care.

4. Optimal maternity care requires cooperation between care providers.

- The PMRG understand the importance of collaboration between clinicians to ensure the best outcome. When a normal pregnancy becomes complex then a midwife will collaborate with an obstetrician, in the same vein when a pregnancy is complicated for example by cardiomyopathy or renal disease the obstetrician will collaborate with the relevant physician. Clear guidance is provided through the Australian College of Midwives developed and Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) endorsed Consultation and Referral Guidelines regarding appropriate collaboration.

- The MBS and any future funding models need to facilitate cooperation between maternity care providers (including obstetricians, midwives, GPs, Aboriginal and Torres Strait Islander health workers and NPs). Circumstances that necessitate the transfer of care or collaboration with another clinician in the antenatal, intrapartum and postpartum period need to be reflected in the MBS, ensuring that the entirety of the professional input is recognised and valued appropriately and neither party is disadvantaged.

Key Issues

Throughout the review process, several consistent themes became apparent to the PMRG, based on extensive group discussions, data and literature reviews, consumer feedback, and stakeholder representation. These themes are relevant not just to the recommendations contained in this report, but also to the current challenges and future directions of maternity care in Australia. The four themes identified were:

1. There is overwhelming evidence that midwifery continuity of care results in outstanding clinical, financial and consumer satisfaction outcomes that benefit families and the community.
2. Across Australia, less than 10 per cent of women can access continuity of midwifery care, despite strong demand. Significant barriers currently prevent consumer access to MBS-rebated midwifery continuity of care in Australia, despite the benefits associated with the model. These barriers include legislative, regulatory and insurance impediments.
3. "Bundled payment" funding models may more appropriately reflect the model and increase the uptake of midwifery continuity of care in Australia. This funding model would also be simpler for consumers, as would a single rebate provided for their maternity care.
4. Optimal maternity care requires cooperation between care providers. While there is compelling evidence that continuity of care by a known midwife results in enhanced outcomes for a woman and baby, collaboration between clinicians is essential to ensure the best outcome for women and babies in all possible scenarios.

Other Issues

Improving access to high-value care and removing structural barriers to midwifery services has been a focus of the PMRG. There is a large body of evidence demonstrating the outstanding clinical outcomes, consumer satisfaction and financial efficiency associated with continuity of care models. However, access to this model of care in Australia is limited.

The Access to Midwifery Care section addresses the issue of access to midwifery care, under two main headings:

- Structural barriers
- Financial Barriers

In outlining these issues the PMRG proposes that the Government further explore:

- Ways of removing or overcoming barriers to access of midwifery services
- Financial models, such as the bundling of services, for midwifery services that supports women over the full term of the pregnancy and the post-natal period

The PMRG suggests that these issues be followed up over the next 18 months.

Consumer impact

The PMRG has developed recommendations that are consistent with Taskforce objectives, with a primary focus on improving the quality of private midwifery services for women. Consumer representatives in the PMRG stressed the importance of a "woman-centred" approach that optimises the environment for her and her growing baby in a way that is important to her and her family. This is enshrined in several of the group's recommendations.

The PMRG's recommendations will benefit mothers and babies in the following ways:

- **Access:** Strengthening midwifery practice in Australia is necessary so that all women, regardless of their location or personal circumstances, have the choice to access a model of care that is safe and consistently evaluated to result in birth outcomes equal or superior to other models of care. Mothers want real birthing choices and support along their journey through pregnancy and into parenthood.
- **Consumer control of their care experience:** Building trust with a known midwife lessens apprehension during pregnancy and ensures a mother's birth preferences are supported. From a consumer perspective, the recommendations in this report are also an important step forward to support consumer choice.
- **High-value care:** The recommendations in this report support midwifery continuity of care, which evidence demonstrates provides high-value care to women. The recommendations to tackle structural barriers to midwifery care in Australia build on the more immediate changes to MBS items proposed in this report.
- **Building a culture of collaboration:** Women value and come to rely on the relationship with their midwife, however there are circumstances that require collaboration between clinicians or the transfer of care in the antenatal, intrapartum and postpartum period in order to provide the best outcome for that woman. It is essential that the MBS reflects these professional inputs appropriately and recognises the importance of both professionals throughout sometimes complex clinical scenarios.

4.7.3 Participating Midwives Reference Group Recommendations

Key recommendations

The PMRG has recommended significant amendments to existing items and the creation of new items. These recommendations promote high-quality care and safe practice through the MBS, in alignment with current guidelines for supporting mothers and their babies through pregnancy and birth.

The PMRG's recommendations are as follows:

Antenatal attendances

1. Include a minimum time for initial antenatal attendances and align the schedule fee with average attendance duration.
2. Amend the antenatal attendance items to appropriately reflect the time they take and introduce a new time tier for long antenatal attendances.
3. Create a new item for complex antenatal attendance leading to a hospital admission.
4. Restrict claiming of maternity care plans to instances where a woman has had at least two prior antenatal attendances.

Intrapartum Care

5. Change the time-tiering structure of intrapartum items to facilitate safe birthing and an earlier handover to a second midwife, if necessary.
6. Increase per-minute rebates for intrapartum items.
7. Enable intrapartum items to be claimed from the commencement of midwifery attendance with the woman for labour care (i.e. outside of hospital).
8. Include homebirth in intrapartum items.

Postnatal attendances

9. Amend the postnatal attendance items to appropriately reflect the time they take and introduce a new time tier for long postnatal attendances.
10. Include mandatory clinical components and increase the minimum time for a six-week postnatal attendance.

Telehealth attendances

11. Include general practitioners (GPs) as eligible specialists for existing telehealth items.
12. Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period.

Lactation and infant feeding

13. Addition of a new item to enable Participating Midwives to conduct ongoing lactation support until an infant is 2 years of age.

Diagnostics and Investigations

14. Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for Participating Midwives as recommended by professional clinical guidelines.

Barriers to Midwifery Continuity of Care

15. Removal of the need for mandated formal collaborative agreements.

The PMRG considers the recommendations on MBS intrapartum items (Recommendations 5 to 8) are a priority, in order to ensure the sustainability of the model for consumers.

Below are the recommendations from the PMRG's report. The recommendations promote safe practice and high-value care through the MBS.

A Note from the Taskforce:

When discussing the PMRG recommendations, the Taskforce noted that a small survey sample – 115 practitioners – was used to inform the PMRG's proposed model of care and concern was expressed around this being a truly representative assertion.

The Taskforce deliberations also questioned whether the MBS is the best model of care for midwifery services. In the long-term, the Taskforce agrees alternative models and pathways and funding mechanisms, outside the MBS, should be explored and considered.

The Taskforce further notes the following should be considered in the long-term:

a. establishment of an intergovernmental group,
b. a holistic review of the existing model,
c. review into whether MBS is the most appropriate pathway for the midwife model of care
d. workforce planning,
e. discussions involving state and territory governments, workforce, peak bodies, colleges etc., and
f. a full investigation of international care models and how they might be incorporated into the Australian system.

Antenatal attendances

Recommendation 1 – Include a minimum duration for initial antenatal attendances and align the schedule fee with average attendance duration

The PMRG recommends:

a. amending the item 82100 descriptor to increase the minimum time to 60 minutes as follows (changes in bold):

item 82100

Initial antenatal professional attendance by a participating midwife, lasting at least **60 minutes**.

and

b. increasing the schedule fee to better reflect the average duration of an initial antenatal attendance (approximately 90 minutes).

Rationale 1

This recommendation focuses on ensuring that the MBS reflects professional standards and high-quality care for consumers. It is based on the following:

- The PMRG agreed that best practice requires an initial attendance of at least 60 minutes (most take more than 90 minutes). Initial antenatal consultations involve:
  - standard clinical care requirements, including physical assessment of mother and foetus,
  - completion of ongoing screening, including ordering, undertaking and reviewing pathology and radiology investigations, and
  - ongoing assessment of psychosocial wellbeing.
- Pregnancy care guidelines, endorsed by the NHMRC, outline the activities that should occur in an initial antenatal attendance to ensure high-quality clinical care (16). The PMRG agreed that these activities cannot be undertaken to a high standard in under 60 minutes.

- The PMRG agreed that although a midwife could feasibly complete high-quality initial antenatal attendances in 60 minutes for women with low-risk pregnancies, without complications, who are having their second or subsequent baby, the attendances take an average of 90 minutes.
- The PMRG conducted a survey of 115 midwives across private and public settings. The average reported initial antenatal attendance duration was 91 minutes.
- Birthrate Plus (BRP) is a midwifery staffing tool used throughout the United Kingdom and adopted by NSW Health to measure workload requirements for midwives. BRP allocates 90 minutes for initial antenatal attendances for women planning to birth at home or in hospital (17).

Note: BRP licensing agreements have also progressed in the ACT and Tasmania.

- The PMRG agreed that a schedule fee increase congruent with the time required to complete a high-quality initial antenatal attendance would more accurately reflect the work involved and would increase access for consumers.

PMRG Recommendation 1 – Endorsed (with amendment) for Government consideration

The Taskforce acknowledges the rationale presented by the PMRG and recommends* in the short-term amending the item 82100 descriptor to increase the minimum time of consultation to 60 minutes.

Note: The Taskforce does not endorse an increase to the item fee as this is not within their remit. While it was agreed that, from a patient perspective, there is a clinical place for longer antenatal assessment items, there is not currently evidence to support a clinical need or proven outcomes to justify antenatal assessments of over 60 minutes.

*this was not a unanimous decision

Recommendation 2 – Amend the antenatal attendance items to appropriately reflect the time they take and introduce a new time tier for long antenatal attendances

The PMRG recommends:

a. amending the item 82105 descriptor to specify a minimum duration of 10 minutes and removing the maximum duration of 40 minutes as follows (changes in bold):

item 82105

Short antenatal professional attendance by a participating midwife, lasting at least 10 minutes.

b. amending the item descriptor to describe the attendance as “routine” rather than “long”. The proposed item descriptor is as follows:

item 82110

Routine antenatal professional attendance by a participating midwife, lasting at least 40 minutes.

c. increasing the schedule fee to better reflect the average duration of a routine antenatal attendance of approximately 60 minutes,

d. creating a new item for a long antenatal attendance of at least 90 minutes as follows:

New item 821AA

Long antenatal professional attendance by a participating midwife, lasting at least 90 minutes.

and

e. setting a schedule fee for item 821AA that is higher than the schedule fee for item 82110 to account for the increased duration.

Rationale 2

This recommendation focuses on ensuring that item time tiers accurately reflect the activities required to provide high-value care, and are appropriately rebated. It is based on the following:

- item 82105: The PMRG agreed that there are instances where short antenatal attendances (10–30 minutes) are appropriate. These visits would most frequently occur in between routine visits, or as a follow-up to a routine visit. For example:
    - A midwife may undertake a basic clinical examination, order pathology tests and explain their purpose to the woman. In a woman with a low-risk pregnancy, this will usually take 10 to 20 minutes.
    - A woman's blood pressure may be "borderline" at the routine visit. The midwife may return later that day or the next day to repeat the blood pressure, perform a urinalysis and physical exam, and discuss signs and symptoms that are important to monitor. This will usually take 10 to 20 minutes.
    - A midwife may need to consult with a woman to explain the outcome of a pathology or diagnostic screening test without further clinical examination. This will usually take 10 to 20 minutes.
- The PMRG agreed that there are no circumstances in which antenatal attendances under 10 minutes provide high-value care to women.
- **item 82110:** The descriptor has been amended to describe this attendance as "routine", rather than "long". The PMRG agreed that a minimum duration of 40 minutes is appropriate for a routine antenatal attendance. NHMRC-endorsed Pregnancy Care Guidelines (16) outline the activities that should occur at a routine antenatal attendance to ensure high-quality clinical care. The PMRG agreed that these activities cannot be undertaken to a high standard in under 40 minutes.
- It is a standard consumer expectation that a routine professional attendance by a participating midwife lasts at least 40 minutes in order to develop the necessary relationship for a partnership between mother and midwife.
- MBS data indicates that more than two-thirds of standard (i.e. not initial) participating midwife antenatal attendances are claimed under item 82110 (based on 2017/2018 data). The PMRG agreed that this is likely to remain the "routine" antenatal time tier, even after introducing a long attendance (more than 90 minutes).
- The PMRG agreed that although a midwife could feasibly complete high-quality routine antenatal attendances in 40 minutes for women with no complications, the attendances take an average of approximately 60 minutes. NHMRC-endorsed Pregnancy Care Guidelines outline the activities that should occur in a routine antenatal attendance to ensure high-quality clinical care. The PMRG agreed that these take 60 minutes on average (16).
- The PMRG conducted a survey of 115 midwives which indicated that the average routine antenatal visit takes approximately 52 minutes.

- The PMRG agreed that a schedule fee increase would promote high-quality routine antenatal attendances, more accurately reflect the work involved, and increase access for consumers.
- **New item 821AA:** A new item is recommended for a long antenatal attendance of at least 90 minutes. The PMRG agreed that there are many instances where antenatal attendances of over 90 minutes provide high-value care. For example:
    - For women who report domestic violence, midwives must undertake several steps to provide high-value care, including counselling, potential referral or admission, education about available services, ensuring the safety of the mother and any existing children, and developing a safety plan. These steps often take over 90 minutes.
    - For women with a disability or significant medical condition, planning many aspects of care requires longer than 90 minutes to ensure that all tests are considered, the woman and partner are counselled, and an appropriately detailed clinical examination is conducted.
    - For women with significant mental health issues, midwives often provide additional support and counselling during pregnancy, which may take over 90 minutes.
    - For women in families with a history of engagement with child safety bodies, each antenatal visit can be complex. Plans are made to refer and support women in preparation for keeping their baby and enabling positive, supportive parenting. These attendances often take over 90 minutes.
- The PMRG noted that in cases of domestic violence and depression, longer antenatal attendances promote a close relationship between a woman and her midwife. This relationship with her "known midwife" contributes to the woman's likelihood to "disclose" modifiable health risks—for example, risk of future domestic violence (to mother, baby or both).
- The PMRG considered introducing a cap on the number of long antenatal attendances that are claimable per pregnancy to prevent low-value use of item 821AA. However, it agreed that this would inadvertently restrict access for complex patients who require more care. The PMRG noted multiple examples of clinical circumstances where more than three antenatal attendances would be required (see the examples listed above).
- The PMRG agreed that use of this item should be reviewed in 12–24 months. The PMRG agreed that patients with high volumes of item 821AA claims would likely be those with mental health conditions or chronic medical conditions. It noted that analysis of 821AA claims across patients with MHTPs and/or GPMPs may provide a basis upon which to assess appropriate use of item 821AA.

PMRG Recommendation 2 – Endorsed (with amendment) for Government consideration

The Taskforce acknowledges the rationale presented by the PMRG and recommends:

a. amending the item 82105 descriptor to specify a minimum duration of 10 minutes and removing the maximum duration of 40 minutes, and

b. amending the item 82110 descriptor to describe the attendance as "routine" rather than "long".

Note: The Taskforce does not support the creation of a new item in this instance. While it was agreed that, from a patient perspective, there is a clinical place for longer antenatal assessment items, there is not currently evidence to support a clinical need or proven outcomes to justify antenatal assessments of over 60 minutes.

Recommendation 3 – Introduce a new item for a complex antenatal attendance leading to a hospital admission

The PMRG recommends:

a. creating a new item for a complex antenatal attendance leading to a hospital admission, as follows:

> **New item 821BB**
>
> Complex antenatal attendance leading to a hospital admission—each professional attendance lasting at least 3 hours, to a maximum of 3 services per pregnancy.

b. capping the number of times item 821BB can be claimed at three services per pregnancy,

c. creating a minimum duration of three hours for this item, and

d. restricting co-claiming with all other antenatal attendances.

Rationale 3

This recommendation focuses on ensuring that women can continue to receive care from their primary carer (participating midwife) when being admitted to hospital. It is based on the following:

- While the availability of access arrangements remains challenging for participating midwives, there has been some improvement. Public health organisations throughout Australia are now offering participating midwives access agreements to enable the admission of women under private midwifery care. Women are not only admitted for labour and birth, but also for complications during the antenatal period.
- This development has resulted in the need to develop a new MBS item for hospital admission during the antenatal period.
- In a midwifery continuity of care model, the midwife is the primary carer for the woman. Regardless of complexity, or the need to collaborate with an obstetrician, the midwife is required to complete the admission procedure, clinical assessment, testing, care planning and any foetal monitoring during and following admission.
- The work involved in these instances can be complex and prolonged, especially in the case of unplanned hospital admissions. The PMRG agreed that a new item would more accurately reflect the work involved in these scenarios and ensure that women have access to higher rebates when admitted to hospital.
- A minimum duration of three hours attendance has been set for this item. The PMRG agreed that this is an appropriate caveat, as under a midwifery continuity of care model, the woman requires continuous attendance from the participating midwife from presentation to hospital through to the finalisation of admission and stabilisation of the woman. In contrast, obstetrician models focus on intermittent attendance for a shorter duration at key points, during which care is often directed over the phone.
- The PMRG agreed that in the case of hospital admissions, the participating midwife may be with the woman for anywhere from two to six hours.
- The PMRG agreed that item 821BB should be used in cases where women are admitted to hospital for which intrapartum items (82120, 82125, 821CC and 821DD) do not apply. The PMRG identified several examples where this may occur, including:

- Women admitted with symptoms of pre-eclampsia (headache, blurred vision) require
  - a full clinical assessment,
  - blood and urine testing,
  - cardiotocography (CTG) monitoring,
  - (potentially) an ultrasound scan,
  - (potentially) medication provision, including steroid loading,
  - education of the woman and family,
  - collaboration with the obstetric team,
  - and ongoing planning.
- Women admitted with antepartum haemorrhage require:
  - a full clinical assessment,
  - blood testing,
  - IV fluids,
  - CTG monitoring,
  - ultrasound scanning,
  - education of the woman and family,
  - collaboration with the obstetric team,
  - and ongoing planning.
- Women admitted with decreased foetal movements require
  - a full clinical assessment,
  - CTG monitoring,
  - ultrasound scan,
  - potentially an assessment for induction of labour or ongoing monitoring,
  - collaboration with the obstetric team, and
  - ongoing planning.

- A cap of three claims per pregnancy has been set for item 821BB. The PMRG agreed that the cap applied to MBS obstetric items 16533 and 16534—which can both be claimed a maximum of three times per pregnancy—is appropriate for item 821BB.
- The PMRG agreed that use of this item should be reviewed in 12 to 24 months.

PMRG Recommendation 3 – Endorsed for Government consideration

The Taskforce supports this recommendation and the PMRG's rationale.

Recommendation 4 – Restrict claiming of maternity care plans to prevent low-value care

The PMRG recommends:

a. restricting claims of item 82115 to instances where the woman has had at least two prior antenatal attendances with the claiming participating midwife in the preceding six months, as follows (changes in bold):

> **item 82115**
>
> Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks, **where the participating midwife has had at least 2 antenatal attendances with the patient in the preceding 6 months**.

b. defining "two prior antenatal attendances" as claims for any of the following:

   (i) Face-to-face antenatal attendances (items 82100, 82105 and 82110), and

   (ii) Telehealth antenatal attendances (items 821FF, 821GG and 821HH).

c. restricting co-claiming with corresponding GP/obstetric items for maternity care plans, so that only one care plan (independent of provider) can be claimed per pregnancy with the items for co-claim restrictions to include:

   (i) item 16590: Planning and management of a pregnancy where the doctor intends to attend the birth

   (ii) item 16591: Planning and management of a pregnancy where the doctor does not intend to attend the birth

   and

d. redistributing savings from reductions in the volume of item 82115 claims into participating midwife items 82110, 82135, 82120, 82125, 821CC and 821DD.

Rationale 4

This recommendation focuses on ensuring that the MBS provides high-quality maternity care to women, based on a midwifery continuity of care model. It is based on the following:

- MBS data (2017) shows that 35 per cent of maternity care plans (item 82115) are claimed without antenatal care claims (items 82100, 82105, 82110) with a private midwife in the preceding 12 months, and 58 per cent are claimed with one or no previous antenatal care claims with a private midwife.
- The PMRG agreed that completing a maternity care plan with one or no prior antenatal attendances does not provide high-value care to consumers.
- The PMRG agreed that although there may be cases where women present late for maternity care, or have attended antenatal attendances with another provider or in the public hospital system, item 82115 should promote a midwifery continuity of care model, which provides high-value care to women.
- The PMRG agreed that introducing a co-claiming restriction would limit use of item 82115 to instances that are high value for patients.

- The PMRG agreed that both telehealth and face-to-face consultations should be considered antenatal attendances when defining this restriction, as its purpose is to promote continuity of care with a given midwife, regardless of how an attendance is undertaken.
- The PMRG agreed that the creation of more than two maternity care plans for a patient, regardless of provider, would be unlikely to provide high-quality care to consumers. To mitigate this, the PMRG agreed that item 82115 should not be co-claimed with item 16590 or 16591 in the same pregnancy.
- Schedule fee increases for items 82110, 82125, 82120 and 82135 and new schedule fees for items 821CC and 821DD are noted throughout this report. The PMRG agreed that savings accrued from changes to item 82115 should be reinvested into these items.

PMRG Recommendation 4 – Endorsed for Government consideration

The Taskforce supports this recommendation in the short-term but agrees alternative funding models and pathways should be explored for a longer-term solution. The Taskforce notes bundled/packaged care could be considered in this case.

Intrapartum care

Recommendation 5 – Amend time tiering of intrapartum items

The PMRG recommends:

a. amending the descriptors of items 82120 and 82125 intrapartum time-tiers as follows (changes in bold):

item 82120

Management of labour for **between 6 and** 12 hours, including **birth where performed**.

item 82125

Management of labour for **between 6 and 12 hours**, including **birth where performed**, when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife).

b. creating two new items mirroring items 82120 and 82125, time tiered at six hours (where time is measured as midwife attendance duration, not labour duration), as follows:

New item 821CC

Management of labour for up to 6 hours, including birth where performed OR attendance and immediate post-birth care at an elective caesarean section.

New item 821DD

Management of labour for up to 6 hours, including birth where performed, when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife).

c. ensuring the explanatory notes for items 82120, 82125, 821CC and 821DD clarify that time should be measured as duration of midwife attendance, not duration of labour,

d. allowing items 82120 and 82125 and the new intrapartum items (821CC and 821DD; see below) to be claimed up to a total of 30 hours attendance by up to two participating midwives (Claiming a 2nd or 3rd intrapartum item should reflect the handover of care between the primary and second midwife or vice versa. A second intrapartum item should not be claimed by either midwife unless care has been provided in the interim by the alternative midwife to ensure safe work conditions),

e. allowing co-claiming with existing intrapartum items 82125 and 82120 to account for two or more midwives attending a labour, and

f. allowing item 821CC to be claimed for a participating midwife's attendance at an elective caesarean section to ensure skin-to-skin contact of mother and baby immediately following birth and initiation of infant feeding in theatre and the recovery unit, until transfer of care to postnatal staff.

Note: This recommendation should be considered alongside Recommendation 6.

Rationale 5

This recommendation focuses on ensuring that the MBS promotes safe clinical practice, in line with professional standards. It is based on the following:

- The existing intrapartum items do not reflect the model of care that participating midwives operate within, and they inadvertently promote unsafe working conditions for midwives and possibly unsafe clinical practice. The current items promote long working sessions and fatigue and restrict the safe handover of care between midwives.
- The current MBS item structure promotes working hours over 12 hours. When a midwife transfers care to a second midwife, rebates are only payable if this occurs more than 12 hours after the woman has been admitted to hospital.
- Participating midwives may have worked long hours providing antenatal care or attending other births prior to arriving at hospital to manage a woman's labour. In addition, midwifery support for labour is often provided at home, with the aim of delaying hospital admission until the woman feels ready to transfer (18; 19). This means that a participating midwife admitting a woman for birth may have already worked prolonged hours in preceding days.
- These long hours put midwives at risk of fatigue and impaired performance, as detailed in multiple government-endorsed guidelines and professional standard documents highlighting occupational health and safety best practice, including:
    - Safe Work Australia's Guide for Managing the Risk of Fatigue at Work highlights three fatigue risks especially applicable to midwives: regular work over 12 hours, less than 10 hours between periods of work, and work often performed between 2 am and 6 am (20).
    - The AMA's National Code of Practice: Hours of Work, Shiftwork and Rostering for Hospital Doctors highlights the increased risk of fatigue and decreased performance associated with working more than 10-hour shifts, having inadequate rest between shifts, and working more than two 14-hour shifts in a given week (21).
    - The Australian Nursing and Midwifery Federation's position on fatigue prevention highlights that midwives should be able to control their risk of fatigue, and that there should be adequate rest between working periods (22).

  - A statement by RANZCOG titled *Fatigue and the Obstetrician Gynaecologist* highlights the difficulty of predicting when women will go into spontaneous labour, and the importance of having colleagues to hand over care to, in order to prevent fatigue (23). This is equally relevant to midwives.

- To manage working hours during birth and labour, participating midwives must be able to flexibly transfer care to a second participating midwife when they deem it appropriate to do so. This is currently not well facilitated by the MBS items.
- Two new items mirroring items 82120 and 82125 have been recommended, each time tiered at up to six hours. The PMRG agreed that two additional items mirroring items 82120 and 82125 but time tiered up to six hours (rather than 12) would enable midwives to hand over care earlier during the intrapartum period.
- The PMRG also agreed that retaining items for longer attendances would allow for situations where a midwife is not fatigued and therefore chooses to remain at a birth for 12 hours as required.
- The descriptor has been updated to reflect modern language. The PMRG agreed that the word "confinement" is rarely used in clinical practice, and that "birth" is a more acceptable term for consumers.
- items 82125, 82120, 821CC and 821DD are claimable in any configuration up to a maximum of 30 hours. The PMRG agreed that this would provide flexibility to practitioners, and access to high-value care and appropriate rebates for patients.
- It also agreed that in long labours, the primary midwife would hand over to a second midwife to negate any impacts as a result of fatigue and may return after a rest to resume caring for the woman in labour.
- The explanatory notes are recommended to be amended to clarify that time should be measured as duration of midwife attendance, not duration of labour. The PMRG agreed that this would more accurately reflect the care that is provided to a woman to ensure optimal quality outcomes.

PMRG Recommendation 5 – Endorsed for Government consideration

The Taskforce agrees with the safe practice components of the rationale presented by the PMRG and – while advising seriously consideration of the implementation implications – supports this recommendation.

Rationale

The Taskforce supports the need to address barriers in improving quality and continuity of care, however, the following implications must be considered and mitigated with safeguards, should the Government endorse this recommendation:

- schedule fees should be carefully considered to reflect appropriate clinical input,
- the likelihood of significant shifts of public midwives to private,
- the subsequent cost-shifting effects of this swing between public and private, and
- whether post C-section should be included in the time brackets.

Recommendation 6 – Increase the per-minute schedule fee for intrapartum care

The PMRG recommends increasing the per-minute schedule fee for intrapartum care, as follows:

a. for items 82120 and 82125, a MBS schedule fee that is 100 per cent higher than the current schedule fee for items 82120 and 82125, and

b. for items 821CC and 821DD, a MBS schedule fee at the same per-minute rate as the existing schedule fee for items 82120 and 82125.

Rationale 6

This recommendation focuses on ensuring that women have adequate access to high-quality intrapartum care, and ensuring cost-effectiveness for the health care system. It is based on the following:

- Midwifery care has been demonstrated to provide high-value care to patients by significantly reducing intervention rates, and to provide value to the health care system by lowering costs (5; 8).
- Under the current MBS structure, there are differences in the rebates available to patients during the intrapartum period, depending on whether they access midwife-led or obstetrician-led care.
- Midwifery and obstetric birth items have equal schedule fees despite requiring different durations of attendance. Obstetric care and midwifery care for "normal" birth is rebated at a similar level (obstetric care item 16519, benefit $525.50; midwifery care item 82120, $565). However, the midwifery items are for 12 hours' attendance, while obstetricians are likely to attend for short and/or intermittent periods during labour.
- The PMRG's recommendation to attach the $565 rebate to a shorter time-tiered item (up to six hours) more accurately reflects the clinical care and attendance requirements for this item.
- Obstetric items include an item for "complex" births, whereas participating midwifery items do not. Obstetric care has a "complex" item (item 16522), which is claimed in nearly 50 per cent of births (MBS statistics 2017/18). Many of the conditions listed, including Mental Health Care Plans, are equally cared for by midwives and obstetricians.
- The recommendation to increase the schedule fee for up to 12 hours of care so that it is similar to the schedule fee for item 16522 is intended to more accurately represent the clinical care requirements and attendance for this item.
- Obstetric items include a series of items covering specific elements of intrapartum care. Participating midwife intrapartum items must cover all elements undertaken by the midwife during the intrapartum period.
- The PMRG agreed that increasing the per-minute rebate rate for intrapartum items would enable more consumers to birth under a midwifery-led continuity of care model, leading to potentially improved outcomes (5), high satisfaction for consumers and lower overall costs for the health care system.

PMRG Recommendation 6 – Not endorsed for Government consideration

The Taskforce agrees this recommendation is better placed for submission to MSAC than for consideration through the MBS Review process.

Recommendation 7 – Enable intrapartum items to be claimed from the time the midwife attends the woman for labour care

The PMRG recommends enabling intrapartum items to be claimed from the time the midwife attends the woman for labour care (i.e. including outside of hospital), by:

a. amending the intrapartum item descriptors (items 82120, 82125, 821CC and 821DD) to include the word "attendance" ("up to 6 hours attendance" or "between 6 and 12 hours attendance") to ensure that the billing periods start whenever the midwife is in attendance for the labour and birth (including out of hospital), and

b. amending the explanatory notes for items 82120, 82125, 821CC and 821DD to explain that the attendance time relating to these items is measured from when attendance starts, including if outside the hospital.

Rationale 7

This recommendation focuses on ensuring that the MBS reflects the activities required to deliver high-value care to patients. It is based on the following:

- Currently, duration of care for items 82120 and 82125 is measured from when the woman is admitted to hospital. The PMRG has recommended changing the explanatory notes to clarify that time should be measured based on the duration of attendance. This would allow the attendance to be claimable out of hospital.
- The need for midwifery support in labour begins at different times for different women. This support is often provided at home, with the aim of delaying hospital admission for as long as possible and providing care in a familiar environment. Measuring the provision of care from admission to hospital does not acknowledge the time that a midwife spends with a woman monitoring her at home in labour. The literature demonstrates that the earlier a woman presents to hospital in labour, the more likely she is to undergo unnecessary interventions (19; 18). Rebating midwifery care provided only in hospital creates an incentive for early presentation, poorer outcomes and low-value care.
- The PMRG agreed that including the word "attendance" in the item descriptor would be an appropriate way to ensure that midwifery support in the home is included in the intrapartum items.

PMRG Recommendation 7 – Endorsed for Government consideration

The Taskforce supports this recommendation and the PMRG's rationale.

Recommendation 8 – Include home birthing in intrapartum items

The PMRG recommends:

a. including birth at home in the intrapartum items, and

b. that medical indemnity insurance, for privately practicing midwives be expanded to support a mother's choice regarding place of birth, including birth at home.

Rationale 8

This recommendation responds to consumer demand and facilitates safe, high-quality care. It is based on the following.

- Every year, families choose to birth their baby at home, some with the care of a participating midwife, some with a non-regulated midwife, some through a public hospital program, and some with no professional care or support (freebirth). Families generally birth at home to be in a familiar place of comfort and control, surrounded and supported by loved ones, without the restrictions and impersonality of a hospital system or because they have had a previous negative experience with hospital birth.

- For families choosing to birth at home, the MBS needs to facilitate a safe model of care by facilitating access to a participating midwife. There is currently no rebate for this, which means that many families cannot afford the care of a participating midwife.
- Multiple studies have demonstrated that homebirths are safe and lead to less birth intervention and high consumer satisfaction. A recent systematic review and meta-analysis of 25 studies evaluated the impact of place of birth on perinatal and maternal outcomes. Authors concluded that high-quality evidence about low-risk pregnancies indicates that place of birth has no statistically significant impact on infant mortality. Women experienced lower rates of perineal trauma and haemorrhage, and higher rates of normal vaginal birth, when undertaking a planned homebirth. The lower odds of maternal morbidity and obstetric intervention support the expansion of birth centre and homebirth options for women with low-risk pregnancies. The authors further noted that, based on the results, they support the expansion of birth centres and homebirth options, as well as systems to support them (24).
- The PMRG noted that there is a robust governance framework to ensure that participating midwives work within an appropriate scope of practice when caring for women who choose to birth at home:
    - NMBA requires compliance with various standards and guidelines (midwife standards for practice)
    - AHPRA at a higher level has a range of standards including around professional indemnity insurance for all health practitioners
    - Midwives require an endorsement for scheduled medicines prior to obtaining a Medicare provider number – including 5000 hours of practice and completion of a midwifery professional review process
    - Medicare requirements
    - Medical Indemnity Group of Australia (provision professional indemnity) requirements which include communication of a care plan with a back-up booking hospital
    - The 'National Midwifery Guidelines for Consultation and Referral' document (25) (endorsed by RANZCOG) which require consultation, referral and transfer for women who have or develop complexity during pregnancy or labour
    - The 'Safety and Quality Framework for Privately Practicing Midwives attending Homebirths' document (26) which regulates compliance with the above guidelines
    - Various hospital guidelines where midwives have visiting access also require a level of consultation, referral and transfer. Non-compliance with these guidelines would result in visiting access for the midwife being withdrawn. This would then have a flow on as regulation asks whether a midwife has had credentialing removed and why.
- Additionally, the various health care complaints commissions of each state are active in addressing reports of inappropriate care by all health practitioners.
- The PMRG agreed that maternity services consumer representatives have clearly communicated the need for birth options, including homebirth.
    - A review of the 832 submissions to the maternity services review in 2009 indicated strong support for home birthing (27).
    - More than 300 public submissions have been received in the PMRG public consultation period requesting access to MBS rebates for homebirth. Consumers reported that access to an MBS rebate for a hospital birth but not a homebirth is discriminatory as the place of birth is the choice of a mother/couple.

  - PMRG members agreed that their clinical experience indicates that more women will choose to birth at home if this option is more readily available.

- The PMRG noted that there are an increasing number of publicly funded homebirth programs throughout Australia, demonstrating state and territory governments' acknowledgement of consumer demand and willingness to support this birth option.
- The PMRG agreed that including homebirth in current MBS items may make freebirths without medical support less likely to occur in the community. The PMRG agreed that there is anecdotal evidence that freebirth rates are increasing in Australia, although formal statistics are lacking.
- The PMRG agreed that access to home birth would support Aboriginal and Torres Strait Islander women to "Birth on Country", contributing to the preservation of their cultural identity and in line with their expressed wishes (28) and national documents endorsed by the Australian Health Ministers Advisory Committee (29).
- The PMRG agreed that the lack of available indemnity insurance for birthing outside of hospital needs to be addressed to ensure successful and safe implementation of MBS-subsidised home birthing. The Commonwealth midwife indemnity support schemes are crucial for participating midwives providing Medicare rebated care including homebirth. The lack of insurance for intrapartum care is a large barrier to participating midwives providing homebirth services resulting in some women choosing unsupported options.
- The Government has provided a Public Indemnity Insurance exemption until 2019, through Medical Insurance Group of Australia (MIGA). While the exemption has permitted home births to continue for the time being, consumers and midwives do not have any certainty past 2019 and there are still many barriers that restrict access to the existing model. Many of these barriers fall outside of the MBS review remit. Highlighting the barriers to birthing options for the community offers an opportunity for escalation and influence to appropriate forums for prioritisation and resolution.

PMRG Recommendation 8 – Not endorsed for Government consideration

In coming to its conclusions, the Taskforce commissioned a systematic review of existing international models and analysed these models for their applicability to the Australian health care system. The Taskforce acknowledges that there are existing and long-standing international models of home birthing. These models are in publicly funded systems and include appropriate collaborative arrangements and mechanisms to support patient safety and best practice, as such, they are not equivalent to the models of care proposed by the PMRG. More evidence is therefore required to assess the maternal and neonatal outcomes of home births in low-risk pregnancies in the Australian setting.

The NHS model, for example, is based on cohesive units (i.e. team care arrangements) with a single vision and end-to-end coordinated service conducted under a capitation system. This is distinctly different from the participating midwife facilitated home birth model proposed by the PMRG, which does not define collaborative arrangements, and which includes high risk home births. In addition, the model proposed by the PMRG does not align with MBS fee for service structures.

The Taskforce further acknowledges that there are access barriers limiting service expansion i.e. indemnity arrangements, low risk definitions and patient safety mechanisms. These barriers fall outside of the MBS Review and require satisfactory resolution.

The Taskforce notes that home birthing does occur presently in Australia through existing and comprehensive public programs. Home births supported by existing healthcare services are

underpinned by defined eligibility criteria and clear collaborative arrangements. These home birth programs are not comparable to the models proposed by PMRG.

See Additional Taskforce Recommendation 4: Investigate an alternative funding model for home birthing for patients with low-risk pregnancies.

Postnatal attendances

Recommendation 9 – Amend the postnatal attendance items and introduce a new item for a long postnatal attendance

The PMRG recommends aligning the time-tiered structure to provide improved health outcomes, by:

a. amending the item 82130 descriptor to set a minimum duration of 20 minutes and remove the maximum duration of 40 minutes, as follows (changes in bold):

Item 82130

Short postnatal professional attendance by a participating midwife, **lasting at least 20 minutes**, within 6 weeks after birth.

b. amending the item 82135 descriptor to describe the attendance as "routine", rather than "long", as follows (changes in bold):

Item 82135

Routine postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after birth.

c. increasing the schedule fee for item 82135 to better reflect the average duration of a routine postnatal attendance of approximately 60 minutes. This attendance includes care of both mother and baby,

and

d. creating a new item (821EE) for a long postnatal attendance of at least 90 minutes, as follows:

New item 821EE

Long postnatal professional attendance by a participating midwife, lasting at least 90 minutes.

Rationale 9

This recommendation creates a time-tiered structure that aligns items and rebates more closely with the work required to provide high-value care. It is based on the following.

- **item 82130:** This recommendation recognises that the midwife is caring for both a mother and a new born infant in the postnatal period, both of whom have distinctive needs.
- The descriptor has been recommended for amendment to specify a minimum duration of 20 minutes. The PMRG agreed that there are instances where short postnatal attendances (20 to 30 minutes) provide high-value care to women. These visits typically occur in between routine visits, or as a follow-up to a routine visit. For example:

  - A midwife may need to conduct a focused examination of a woman or baby, rather than a comprehensive examination. This may include checking breast engorgement, temperature or blood pressure, or checking for infection. This will also involve discussion with the woman and her partner. This would usually take 20 to 30 minutes.
  - A midwife may need to review pathology and/or administer medication such as vitamin K or anti-D, or repeat blood tests such as new born screening. Again, these will also involve discussion with the woman and potentially education of the woman and her partner. This would usually take 20 to 30 minutes.

- The PMRG agreed that there are no circumstances in which postnatal attendances under 20 minutes would provide high-value care to women.
- **item 82135:** The descriptor has been amended to describe this attendance as "routine". The National Institute for Care Excellence (NICE) guidelines for postnatal care list the activities that should occur at a routine postnatal visit to ensure high-quality care for both the mother and her infant (30). The PMRG agreed that these activities cannot be undertaken to a high standard in under 40 minutes.
- The PMRG agreed that although a midwife could feasibly complete high-quality routine postnatal attendances in 40 minutes for women with no complications, the attendances take an average of approximately 60 minutes.
- The PMRG conducted a survey of 115 midwives which showed that routine postnatal attendances take an average of 63 minutes. The PMRG noted that postnatal attendances often occur at the woman's home, meaning that midwives must travel (sometimes significant distances) between appointments. The PMRG agreed that this additional time requirement (not counted in the above survey) further supports the recommendation to increase the schedule fee for this item.
- The PMRG agreed that a schedule fee increase would promote high-quality routine postnatal attendances, more accurately reflect the work involved for both the mother and the baby, and increase access for consumers.
- **New item 821EE:** A new item has been recommended for a long postnatal attendance of at least 90 minutes. The PMRG agreed that there are numerous instances where postnatal attendances of over 90 minutes provide high-value care for women. For example:
  - For women with significant breastfeeding issues, there is a need to observe a breastfeed and conduct a clinical assessment of mother and baby. The breastfeed and associated education and discussions will require longer than 90 minutes.
  - Many women are discharged from hospital within four to six hours of birth. The subsequent home visit will not only encompass all routine clinical checks and assessments, as per the NICE guidelines, but also a bath demonstration, feeding support and education. These activities take over 90 minutes.
- Given that item 821EE has particular relevance for breastfeeding, it is important to note the following:
  - There is high-quality evidence that breastfeeding to a minimum of six months of age protects infants from a variety of infections, enhances emotional and cognitive development, and reduces maternal risk of perinatal depression and breast and ovarian cancer later in life (28).
  - In Australia, despite 92 per cent of women initiating breastfeeding, the proportion who continue to exclusively breastfeed falls to 80 per cent in the first week of a baby's life, then 56 per cent by three months. Only 14 per cent continue breastfeeding to six months. This means that Australia falls well below the WHO recommendation that women exclusively breastfeed to six months (32; 33).

- The PMRG agreed that enabling longer consultations through a new item would support women to breastfeed.

PMRG Recommendation 9 – Endorsed (with amendment) for Government consideration

The Taskforce acknowledges the rationale presented by the PMRG and recommends:

a. amending the item 82130 descriptor to set a minimum duration of 20 minutes and remove the maximum duration of 40 minutes, and

b. amending the item 82135 descriptor to describe the attendance as "routine", rather than "long.

Note: The Taskforce does not support the creation of a new item in this instance. While it was agreed that, from a patient perspective, there is a clinical place for longer antenatal assessment items, there is not currently evidence to support a clinical need or proven outcomes to justify postnatal assessments of over 60 minutes.

Recommendation 10 – Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance

The PMRG recommends amending the item 82140 descriptor to introduce a minimum duration of 60 minutes, and to include a birth debrief and mental health screening, as follows (changes in bold):

Item 82140

Postnatal professional attendance by a participating midwife with a woman not less than 6 weeks but not more than 7 weeks after birth of a baby**, lasting at least 60 minutes, and including:**

a. a labour and birth debrief, and

b. a mental health screening.

Rationale 10

This recommendation focuses on ensuring that the MBS promotes high-quality maternity care, in line with professional standards. It is based on the following:

- The PMRG agreed that a postnatal attendance between six and seven weeks is of high value for women, ensuring adequate handover of care to primary care providers.
- The Pregnancy Care Guidelines outline the activities that should occur in a final postnatal attendance (16). The PMRG agreed that these activities could not be completed to a high standard in less than one hour.
- The PMRG agreed that birth debriefing and mental health screening should specifically be enshrined in the descriptor for item 82140 because they are essential components of finalising clinical care, and because they allow for the detection of potential mental health issues prior to handover/return to the woman's primary care provider. If a condition remains unidentified and the woman does not receive support, there can be long-term consequences for her health and wellbeing, her relationship with her partner and the baby's wellbeing. Birth trauma and post-traumatic stress disorder are increasingly acknowledged and recognised in post-partum women. The final contact with a woman's "known" midwife is a vital opportunity to screen for risk and, if appropriate, refer to the best support mechanisms.

PMRG Recommendation 10 – Endorsed (with amendment) for Government consideration

The Taskforce acknowledges the rationale presented by the PMRG and, noting the existing item description, recommends changes to the item descriptor as follows (proposed changes in bold):

item 82140

Postnatal professional attendance by a participating midwife with a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby**, lasting at least 60 minutes, including**:

(a) a comprehensive examination of patient and baby to ensure normal postnatal recovery,

(b) **a labour and birth debrief,**

(c) **a mental health screening,**

and

(d) referral of the patient to a GP for the ongoing care of the patient and baby.

Telehealth attendances

Recommendation 11 – Include GPs as eligible specialists for existing telehealth items

The PMRG recommends amending the item descriptors (items 82151 and 82152) to include GPs in the list of doctors who can participate in the video consultation, as follows (changes in bold):

Item 82151

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics, obstetrics **or general practice**.

and

Item 82152

A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient participating in a video consultation with a specialist / consultant in paediatrics or obstetrics **or general practice**.

Rationale 11

This recommendation focuses on ensuring that the MBS provides adequate access to high-quality clinical services for women. It is based on the following:

- The PMRG agreed that there is a need to expand midwifery services to rural and remote populations. There is a clear relationship between distance to maternity services and poorer clinical and psychosocial outcomes (31; 32). Key Australian maternity documents cite rural and remote maternal location as a barrier to quality maternity care (16; 33). The Australian Rural Birth Index project found that maternity services in Australia do not match population need (34).

- The PMRG agreed that telehealth items are one way to drive increased access to midwifery services for rural and remote populations.
- Current midwifery telehealth items are underutilised. MBS data shows that items 82150–82152 were claimed a total of 18 times in 2016/17. The PMRG proposed two reasons for this low service volume:
    - Telehealth attendances must include a specialist obstetrician or paediatrician, who often does not have the time to undertake telehealth consultations on an ad-hoc basis.
    - Claims for items 82150–82152 require the participating paediatrician or obstetrician to have submitted an MBS claim for their participation in the teleconference. PMRG members with experience using these items highlighted that specialist practitioners do not always bill for these attendances as they are a small part of their scope of practice. As such, MBS service volumes may be artificially low.
- The PMRG agreed that including GPs in the descriptors for current telehealth items would be beneficial to women accessing midwifery care. GPs (especially those with a sub-specialisation in obstetrics) are well placed to deliver medical advice to women and their caring midwives during pregnancy. The PMRG identified two potential use cases for this:
    - Women who live in rural or remote regions may have their early antenatal care primarily with their GP and may plan to birth in the city with midwifery continuity of care. There may be occasions when a telehealth consult will occur between the woman, the GP who is providing her antenatal care and the intended midwife for intrapartum and birth care.
    - There may be occasions when the women and her primary midwife will benefit from access to their regular GP for a team discussion. This discussion may include the results and implications of recent tests or detail on the ongoing management of chronic conditions. Ensuring key clinicians such as the woman's GP are actively involved in her pregnancy will optimise outcomes.
- GPs are better dispersed across Australian rural and remote areas than obstetricians and paediatricians. As such, women and their midwives may be able to undertake telehealth consultations with GPs more proximal to women's homes. The PMRG agreed that this may drive more local continuity of care for women and these practitioners. The number of practitioners eligible to deliver these services will increase, driving increased access and overcoming the time constraints of specialists.
- The PMRG agreed that use of this item should be reviewed in 12 to 24 months.

PMRG Recommendation 11 – Referred

This recommendation was referred to the Telehealth Working Group.

Recommendation 12 – Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period

The PMRG recommends:

a. creating three new telehealth items (821FF, 821GG and 821HH) for women consulting with a midwife via teleconference, with a nurse, Aboriginal and Torres Strait Islander health worker or professional, or another midwife on the patient side,

b. creating time tiers for these new items in line with items 82150–82152,

c. the proposed new item descriptors be as follows:

New item 821FF – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

New item 821GG

A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife

New item 821HH

A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

and

d. adding the following restrictions, in line with items 82150–82152:

(i) The woman must not be an admitted patient.

(ii) The woman must be located both within a telehealth-eligible area, and at least 35 kilometres by road from the participating midwife mentioned in the above descriptors.

(iii) The woman must reside in a rural or remote region (defined as Modified Monash Model areas 4–7).

(iv) The midwife must be intending to undertake the woman's birth, or in the case of postnatal care, be the primary provider of postnatal care or breastfeeding support for the woman.

Rationale 12

This recommendation focuses on ensuring that consumers in remote and rural areas can access high-quality, cost-effective maternity care. It is based on the following.

- As noted in Recommendation 9, the PMRG agreed that there is a need to expand midwifery services to rural and remote populations.
- Members of the PMRG who work primarily with Indigenous women or remote/rural services report that most of these women have access to a health worker such as a nurse. The identified telehealth need is for that worker and the women to be able to consult with a midwife.
- The PMRG agreed that there are multiple instances where a participating midwife could provide high-value care to a woman via telehealth without the participation of a medical professional. For example:
    - Women who live or work in rural or remote areas (for example, Anangu Pitjantjatjara Yankunytjatjara (APY) lands) but are planning to come to the city to birth can access midwife care regularly throughout their pregnancy and build rapport with their midwife before seeing them face to face. This provides opportunities for explanation and education.

  - A woman residing in a remote area might attend a number of antenatal consultations via telehealth with a participating midwife who is her intended midwife for labour and birth. Due to the remote location, all antenatal consults cannot be attended face to face.
  - Women returning to remote areas after birth can consult via telehealth with the known birthing midwife, providing continuity of care.
  - Women who live several hours away from their midwife can check in for antenatal discussion and education. A local health worker can perform a basic clinical examination.

- The PMRG agreed that having practitioners on the patient side during these consultations is important to enable appropriate observations and basic examinations during the attendance.
- The PMRG agreed to include midwives in the list of eligible practitioners on the patient side under this item. The PMRG agreed that a participating midwife consulting with another midwife via teleconference would be particularly useful when women are planning on moving to a metropolitan area to give birth. For example:
  - Women may move from a rural/remote area to the city for birth. Telehealth offers the opportunity for midwives to introduce rural and remote women to the participating midwife who will be undertaking their birth in a metropolitan region. This allows familiarity for those who are unable to meet their participating midwife face to face.
  - Women who live in rural or remote regions may be experiencing breastfeeding challenges. The remote area midwife may not have any additional training in this area and may request help from a specialised midwife in the city. Together with the woman, they may be able to provide an assessment of attachment, remedial assistance and support to enable ongoing breastfeeding.
- The PMRG noted the importance of continuity of care in ensuring high-value use of telehealth items in a fee-for-service system and has targeted its recommendations to promote this.

PMRG Recommendation 12 – Referred

This recommendation was referred to the Telehealth Working Group.

Enhance access to lactation support

- The short and long-term benefits of breastfeeding are widely known and well understood. The WHO recommends breastfeeding to a minimum of 6 months and into the second year of life (32).
- Australia has a high initiation rate for breastfeeding at 92-98% of women, but this drops off rapidly to 80% fully breastfed (no other food or fluid) by the end of the first week. At one month this figure declines to 71%, at three months to 56%, and down to 14% at six months post birth (29).
- One of the most significant causes of the reduction in breastfeeding rates in the postnatal period and the following 12 – 24 months is a lack of support and understanding around breastfeeding.
- While midwives have a good understanding of lactation there are complex scenarios that midwives with specialty education and expertise can address.
- The PMRG noted a number of breastfeeding trends in Australia:
  - In Australia women are not exposed to breastfeeding as much as other countries for cultural reasons.

- The fragmentation of care typically received around pregnancy and birth further erodes the opportunity to educate and inform women and their families about the benefits of breastfeeding.

Recommendation 13 – Add a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support

The PMRG recommends:

a. the addition of a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support, and

b. that the proposed new item descriptor be as follows:

> **New item XXXX – example text**
>
> Professional attendance by a participating midwife with a woman during postnatal period until no more than 2 years after birth of a baby for the purpose of lactation support, **lasting at least 60 minutes.**

The PMRG suggests that items could be restricted to 6 consults per 2- year period, except where a second pregnancy occurs in this 2 year period. This suggestion focusses on providing relevant and high value support for new mothers.

Rationale 13

- The PMRG agreed that based on clinical experience it takes at least 60 minutes to deliver high value lactation support.
- The PMRG agreed that breastfeeding should be promoted until at least 2 years of age, in line with WHO recommendations that promote (32):
  - early initiation of breastfeeding within 1 hour of birth,
  - exclusive breastfeeding for the first 6 months of life, and
  - introduction of nutritionally adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond.
- The PMRG noted that there is sound evidence regarding the health benefits of breast feeding in addition to the indirect cost savings to the health system. 'For the child who is not breastfed, or is breast fed for shorter lengths of time, there is an increased risk of:
  - SIDS
  - gastrointestinal infections
  - respiratory infections
  - ear infections
  - necrotising enterocolitis in premature babies
  - sepsis in premature babies
  - dental malocclusions
  - overweight and obesity

  - lower IQ
    - For the mother, not breastfeeding increases the risk of:
  - breast cancer
  - ovarian cancer (38)

- The PMRG agreed that participating midwives are well equipped to provide continuing lactation support after the 6 weeks post-partum period is completed.
- The PMRG identified a number of examples where a lactation consultation up until a child is 2 years of age would be beneficial and facilitate ongoing lactation:
  - Mastitis/breast abscess after the first 6 weeks
  - Breast refusal
  - Maternal return to work
  - Issues with maintaining supply, dysmorphic milk ejection reflex, nipple vasospasm
  - Slow weight gain/failure to thrive
  - Oro-facial/developmental issues
  - Breastfeeding through pregnancy/tandem feeding
  - Post maternal surgery or medical treatment for an acute or chronic condition.
  - Inducing lactation in the case of adoption or same sex couple.
  - Re-lactation-where the woman may change her mind or breast milk may be considered part of the child's medical management (For example leukaemia).
  - Counselling during pregnancy after a lactation failure with previous child.
- The PMRG notes the following evidence in support of the effectiveness of continuing lactation support:
  - A randomised controlled trial investigating the impact of prenatal and postnatal lactation consultant interventions found that the intervention was effective in increasing breastfeeding duration and intensity (39).

PMRG Recommendation 13 – Not endorsed for Government consideration

The Taskforce supports the notion of lactation support but does not support the inclusion of a new item noting that breast feeding support is provided as part of the postnatal care delivered by a participating midwife (i.e. post-natal item numbers up to six weeks).

There is also already an expected handover back to the primary health care provider at six weeks, and any extended time periods are and should continue to be coordinated by the primary care provider.

Facilitating the Consumer Journey – expanding midwife access to pathology and diagnostic investigations

- The MBS does not allow participating midwives to claim a number of items for standard and regularly required pathology and diagnostic/screening tests. These tests are necessary to provide high quality

maternity care, and most are specifically outlined in the NHMRC endorsed Pregnancy Care guidelines (16).

- The omission of these investigations causes inefficiencies in the MBS. Women often attend a consultation with their participating midwife, where the need for a specific test is determined. If the Midwife is unauthorised to order the test, the woman must attend an MBS-rebateable GP consultation for a second MBS consult to gain access to MBS rebates for the test. This process introduces additional cost into the MBS, with no added benefit.

Recommendation 14 - Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for participating midwives as recommended by professional clinical guidelines

Below is the list of pathology and diagnostic investigations the PMRG recommend should be added to the MBS rebate schedule for participating midwives:

Table 2: PMRG Report – Pathology and diagnostic investigations that the PMRG recommends should be available for participating midwives

Test	Proposed Rationale
Thyroid function test/Thyroid antibodies	Thyroid testing is recommended for pregnant women who are at increased risk of thyroid dysfunction because of the range of adverse maternal and neonatal outcomes associated with overt hypothyroidism and hyperthyroidism (40).
Iron studies/Ferritin/ B12/Folate	Routinely testing pregnant women for haemoglobin concentration in early pregnancy and at 28 weeks gestation is recommended. Pending the haemoglobin results further diagnostic tests including serum ferritin, folate and B12 are required in order to diagnose anaemia. In areas where prevalence of iron-deficiency anaemia are high Ferritin testing should be considered at the first antenatal visit (40).
Fasting bile acids	The collection of liver function tests and fasting bile acids is recommended to diagnose Obstetric Cholestasis when otherwise unexplained pruritus of pregnancy occurs (41).
Kleihauer	It is recommended that all women with a Rhesus (D) negative blood group who deliver an Rh (D) - positive baby should have quantification of feto-maternal haemorrhage to guide the appropriate dose of anti-D prophylaxis. All women who are given Anti-D in response to a potentially sensitizing event should also have the magnitude of potential feto-maternal haemorrhage assessed (42).
Varicella	It is recommended that serology be attended when a pregnant woman with unknown immune status is exposed to the Varicella Zoster infection, in order to determine if the woman is eligible to receive Varicella Zoster immunoglobulin (43)
Parvovirus	It is recommended that pregnant women who have been exposed to parvovirus infection should be offered serological testing for parvovirus-specific IgG to determine their susceptibility. The diagnosis of parvovirus infection is usually made, serologically and is usually detectable within 1-3 weeks of exposure and lasts for 2-3 months (43).
Cytomegalovirus	Serology testing for CMV should be offered to women who come in to frequent contact with large numbers of very young children (e.g. child care workers). CMV testing should also be offered to pregnant women if they have symptoms suggestive of CMV that are not attributable to another specific infection or when imaging findings suggest foetal infection (40).
Herpes virus swab	Collection of a HSV PCR from the genital tract is recommended for a pregnant woman with a suspected first episode of genital herpes. Serology for HSV-1 and 2 is also attended. (Ref. Management of Perinatal Infections, Australian Society of Infectious Diseases 2014)
Vitamin D	It is recommended that serology be considered for women at high risk of suboptimal Vitamin D levels (40).
HbA1c	It is recommended that 'women with risk factors for Diabetes be offered early testing.' While OGTT is the preferred screen clinical guidelines recommend HbA1c in the first trimester for those women who cannot tolerate the OGTT (e.g. due to nausea and vomiting) (40).
Postnatal abdominal scan	The use of ultrasound to diagnose retained products of conception (RPOC) in the postnatal period is associated with a significant 'false-positive rate'. However ultrasound examination is

Test	Proposed Rationale
	attended before considering a D&C due to the increased risk of uterine perforation with a surgical procedure in the postpartum period. Referring a woman to an Obstetrician for RPOC with the ultrasound findings already attended ensures that the collaborating medical officer has all available information with which to make a decision and prevents the woman attending a medical consult, being referred for an ultrasound and then returning for a follow-up consult.
Growth and wellbeing scans	Ultrasound assessment of foetal size should be attended when there are fundal height discrepancies and risk factors for a small for gestational age foetus (40).

Rationale 14

- The omission of standard/regularly required pathology and diagnostic investigations from the Midwifery MBS rebate schedule results in increased costs to the MBS system (two MBS consultations), creates inconvenience for the consumer and could possibly lead to low value care.
- The NHMRC endorsed Pregnancy Care Guidelines (40) outline the requirements to perform many of the above pathology and diagnostic investigations. Other investigations listed are clearly best practice and will be performed upon referral to a GP or obstetrician under the current system. In the case of referral to another clinician it is best practice and time efficient to attend appropriate screening or diagnostics prior to referral in order that the receiving clinician has all of the relevant information.
- This recommendation supports technological progress such as patient diagnostic results being directly uploaded and available for all health practitioners to view on 'My Health Record'. Such strategies have already launched in Queensland and when more widely instituted will reduce the duplication that occurs with multiple providers ordering the same diagnostics for the same patients.

PMRG Recommendation 14 – Not endorsed for Government consideration

Due to variation in scope of practice and collaborative arrangements within the profession, the Taskforce is concerned there is a risk to patient safety if the participating midwife is not suitably trained to interpret results and respond appropriately. The Taskforce also notes that additional tests being sought would require further access and governance processes that have not been properly considered.

Improving Women's Access to Midwifery Care by Removal of Mandated Collaborative Agreements

- Mandated collaborative arrangements for endorsed midwives were introduced in 2010 as a prerequisite to an endorsed midwife providing health care services subsidised by the MBS. This was a ministerial determination made at the time of the legislative amendments to allow patient access to rebates through the MBS for eligible midwife services. The legislation dictates that an endorsed Midwife must have a formal collaborative agreement with an Obstetric medical practitioner or a Health Service with an Obstetric Service before they are eligible for an MBS provider number. The aim of the legislation was to avoid fragmented care.
- The cost of private healthcare by a Midwife or Obstetrician can be a barrier to many families however an MBS rebate can make the care affordable and accessible. It has become evident that rather than facilitating access to Midwifery care legislation has in fact restricted the capacity for endorsed Midwives to establish a private practice that offers MBS rebates.
- No other profession is reliant on another single professional to determine whether they are able to establish a private practice. A GP is not reliant on a Psychiatrist signing a formal agreement before they can care for or refer complex mental health patients. An Obstetrician is not reliant on an

Endocrinologist signing a formal agreement before they can care for or refer complex diabetic patients. And yet a Midwife is reliant on an individual Obstetric medical practitioner or healthcare organisation signing a formal collaborative agreement before they are eligible to apply for a Medicare Provider number and thus offer MBS rebates to families under their care.

- The feedback from endorsed midwives in 2019 is that very few Obstetricians or health organisations when approached will agree to formal collaborative agreements and this is evidenced by the minimal number of health organisations throughout Australia offering access agreements to endorsed Midwives.
- Endorsed Midwives need capacity to freely collaborate and refer as other professionals are permitted to do. Midwives who have fulfilled the multitude of compliance items to achieve endorsement should be eligible to apply for a Medicare Provider number without being reliant on the signed endorsement of another individual clinician or health care organisation.

Recommendation 15 - Removal of the need for mandated formal collaborative agreements

The PMRG recommends that the legislation requiring a collaborative arrangement be rescinded for endorsed midwives. This would require legislative amendment and alteration to the MBS item descriptors.

Rationale 15

This recommendation focuses on the provision of affordable, universal and high-value care for women in line with the recommendation to increase access to midwifery continuity of care as a priority. It is based on the following:

- The PMRG noted that this recommendation would enable more Participating Midwives to access MBS rebates thus increasing the affordability and access for women to midwifery care.
- The PMRG noted that a majority of the submissions received from consumers and stakeholders during the public consultation period, raised concerns regarding the barriers caused by mandated collaborative agreements. These submissions requested removal of this mandated requirement from legislation and Medicare.
- Endorsed midwives reported during the consultation period that formal collaborative agreements were difficult to source and are an impediment to the establishment of an affordable private practice and development of this model.
- Some of the reasons for this are:
    - Collaborative arrangements can be difficult to develop, particularly in rural and remote areas (44; 45). The availability and accessibility of medical practitioners with whom an endorsed midwife can establish the mandated collaborative arrangement remains a challenge in some rural and remote locations, reducing patient access to endorsed midwife care. In addition, difficulty engaging a medical practitioner to collaborate with and resistance to endorsed midwife referrals has been reported by some endorsed midwives.
    - Requiring an endorsed midwife to establish a formal collaborative agreement makes them dependent on the willingness and availability of individual medical practitioners to participate (46). In turn there is no mandate that medical practitioners must collaborate.
    - Collaborative arrangements can affect perceptions of the autonomy of an endorsed midwife, including their professional recognition and sense of control as legitimate health care providers (47) and leads to perception of medical control over the woman's care

- The original reasons behind establishing collaborative arrangements, such as avoiding fragmented care (48; 49), do not justify the continued requirement for these arrangements as there is no evidence that collaborative arrangements have significantly contributed to a reduction in fragmented care. Neither the presence nor the effectiveness of collaborative arrangements has been monitored by DoH since implementation of the determination in 2010.
    - Experience demonstrates that eligible midwives effectively collaborate without formal agreements. The National Health and Medical Research Council developed a guidance document for endorsed midwives based on the evidence surrounding midwifery collaborative practice (50).
    - Collaboration is ingrained in midwifery philosophy and is represented in the NMBA standards for practice and the professional guidelines (Australian College of Midwives National Midwifery Guidelines for Consultation and referral). These standards are grounded in actual (as opposed to aspirational) practice and are evidence-based (51). To meet the standards of practice (against which midwives are audited), collaborative practice must occur. A separate mandated collaborative arrangement is not required.
    - There is no evidence to indicate that formal collaboration improves safety.
    - There is no evidence to suggest that formal collaborative arrangements increase collaboration between midwives and medical practitioners and there is evidence that it has led to further cultural breakdown between the midwifery and medical profession (52).
    - Formal collaborative arrangements are not required in comparable countries. For example, mandated collaborative arrangements are not required for midwives practicing in New Zealand. Nurses and midwives are the only health professionals required by law to establish an arrangement with a medical officer in order to participate in the MBS.

PMRG Recommendation 15 – Not endorsed for Government consideration

The Taskforce has considered the arguments presented carefully but cannot support this recommendations as the risks of removing Collaborative Arrangements will impact patient safety. The Taskforce agrees Collaborative Arrangements are critically important, noting collaboration is an essential protection for both the patient (and unborn child), especially in rural and remote areas. Having a team providing patient care promotes minimal fragmentation of care by ensuring responsibility and accountability.

The Taskforce does not view Collaborative Arrangements as an administrative limitation, rather a process designed to promote a cooperative culture and underpin patient (and child) safety.

The Taskforce does, however, note the difficulties to date in achieving Collaborative Arrangements within the current framework, and agrees that significant research needs to be done on how to address and streamline current administrative barriers, without removing the existing requirement.

See the Taskforce's additional recommendation on Collaborative Arrangements.

Access to midwifery care

Consumer access to midwifery continuity of care

Women value supportive, respectful and relational care such as that provided by the continuity of caregiver. Additionally, women wanting to birth safely and naturally, with lower intervention approaches consider Midwifery care as essential to achieving these objectives (12). Improving access to high-value care and removing financial and structural barriers to midwifery services has been a focus of the PMRG. There is

a large body of evidence demonstrating the outstanding clinical outcomes, consumer satisfaction and financial efficiency associated with continuity of care models. However, access to this model of care in Australia is limited. Public hospital midwifery continuity models are limited in number and size, and despite the introduction of Medicare rebates for midwifery care, there are lower than predicted numbers of midwives working in this model (37; 29).

The barriers to MBS-rebateable midwifery care fall into two main categories: financial and structural. These barriers presented a range of issues for the PMRG which were outside of the scope of the review process. Therefore due to the demand from consumers, efficacy of midwifery continuity of care and the evidence based benefits of this model, it is the overall recommendation of the PMRG that a further process utilising a similar methodology to the MBS review be established as a matter of priority, reporting to the Health Minister to examine more fulsomely the barriers and solutions to the expansion of Medicare rebated midwifery care.

Structural barriers

Midwives working in an MBS eligible model are absolutely held to account with regards to their professional practice through a myriad of compliance items they must fulfil for the NMBA, Medicare, Federal legislation, State policy, professional guidelines in addition to the credentialing organisation requirements of which many of these are required to be demonstrated every 1 to 3 years. The PMRG are in agreeance that robust requirements should exist to ensure quality and safe care. However, it is evident that some of the current requirements for midwives to enter private practice may be onerous as compared to other professions. The following regulatory barriers are additional to those already addressed earlier in this report and the PMRG recommends that government consider how they can be addressed.

Professional Indemnity Insurance

There is only one option for insurance available for participating midwives: insurance available under Government contract with MIGA, through the Commonwealth midwife indemnity support schemes. To be eligible for this indemnity coverage Participating Midwives are first required:

- to meet national registration requirements,
- to undertake endorsement with the NMBA,
- be self-employed; be directors of their own company, and
- have written collaborative agreements with doctors or healthcare services that employ obstetricians.

Midwives are then required to purchase individual professional indemnity insurance with payment of five years of run-off cover. This can be prohibitive to entering private practice.

The Commonwealth midwife indemnity support schemes are crucial for participating midwives providing Medicare rebated care, including homebirth care. The current lack of insurance for intrapartum and birth care at home is a barrier to midwives providing homebirth services, resulting in women occasionally choosing unsupported options. As discussed, the Government has provided a Public Indemnity Insurance exemption until 2019, through MIGA. While the exemption has permitted home births to continue for the time being, consumers and midwives do not have any certainty for the future.

Recency of practice

There is a requirement that midwives have undertaken 5000 clinical care hours in the previous six years prior to obtaining NMBA endorsement and a provider number. This caveat for instance prevents a very experienced midwife who has been on reduced hours following maternity leave from transitioning to private practice. The requirements should be reviewed, and consideration given to the removal of the

provision that hours are amassed within the last six years, NMBA requirements stipulating recency of practice could apply here. There is no evidence that midwives require a specific amount of experience before making a transition into private practice, particularly with support. The precedent that was used to determine the number of required hours concerned NPs. NPs have an extended scope of practice as compared to registered nurses. Participating midwives are working in the very role they studied and trained to undertake, they are not working in roles with extended scopes of practice.

Midwifery Prescribing Pathway

The postgraduate prescribing qualification requirement (as opposed to including prescribing courses as a component of undergraduate midwifery education) is based on NPs, who require a large prescribing formulary in addition to their original scope of practice. Midwives require a limited prescribing formulary that supports the scope of practice they originally studied. Prescribing for midwives should be included in Midwifery undergraduate education programs.

Early career Pathway to Midwifery Private Practice

There is no pathway into private practice as there are no Medicare rebates for a midwife who does not have endorsement. There is no funding model to support early career work in midwifery continuity of care in private practice, limiting women's access to a greater number of midwives. However, expansion of MBS items that currently exist for midwives working "for and on behalf of and under the supervision of medical practitioners" to include "participating midwives" would allow midwives who are working towards becoming participating midwives to transition under the supervision of a participating midwife. item-level changes could be as follows:

- **item 16400:** Extend this item to include "for and on behalf of and under the supervision of participating midwives" and remove the requirement for Modified Monash Model locality.
- **item 16408:** Extend this item to include "for and on behalf of and under the supervision of participating midwives" for up to six postnatal visits.

Financial barriers

The financial barriers to midwifery continuity of care have been articulated throughout this report with common themes being:

- Rebates do not align with the cost of service provision, particularly for intrapartum items. Like other clinical professions, participating midwives have a full set of practice overheads, including practice accommodation, insurance, motor vehicle costs, administration overheads and more.
- Low rebates mean that out-of-pocket payments are high, restricting access to a small number of women.

There are additional financial barriers that require consideration which were outside the scope of this review:

- Private health insurers will not enter into agreements with midwives for "no gap" or "known gap" arrangements, limiting the private health rebates available to women.
- The fee-for-service model is not well aligned to reflect continuity of care.

Bundled payment funding model

Bundled payment funding for midwifery care should be explored. The PMRG agreed that the current MBS fee-for-service model fits poorly with low-risk primary maternity care. It does not recognise midwifery

services provided between consultations (for example, via phone, Skype, on call, case review, pathology review, diagnostics), or the fact that a midwife may be on call 24/7 for her "caseload" of women. It does not drive continuity of care for women.

The Independent Hospital Pricing Authority (IHPA) has explored the feasibility of bundled payments for women with low-risk pregnancies (9). Specifically, the IHPA states that:

- There is potential to better align pricing incentives across settings by introducing bundled pricing approaches.
- Uncomplicated maternity care services are potentially amenable to bundled pricing as they follow a relatively predictable care pathway.
- Bundled pricing for uncomplicated maternity care could potentially support the implementation of nationally agreed-upon guidelines.

The PMRG suggests the following bundles for maternity care episodes could be considered:

- Antenatal (one, two or three items):
    - First trimester:
        - booking visit (including existing requirements from the Pregnancy Care Guidelines),
        - call cover throughout pregnancy,
        - organisation and review of first trimester screening, and
        - baseline mental health screening (minimum of one visit).
    - Second trimester:
        - pregnancy care visits, including organisation and review of morphology scan,
        - on call care,
        - care plan with pregnancy management, and
        - planning fees and discussions (minimum of two to three visits).
    - Third trimester:
        - pregnancy care visits (number increased),
        - on call care,
        - mental health screening, and
        - education (minimum of four to five visits).
- Labour and birth:
    - All attendances relating to labour and birth, labour management up to 30 hours by a primary participating midwife and/or additional midwife as required to safely manage fatigue and wellbeing, conduct of birth if occurs (unless transferred to a medical practitioner for escalation of risk), care for the immediate postpartum period.
- Postnatal:

- Postnatal care from birth until six completed weeks for both mother and baby including mental health screening, birth debrief, on-call support (minimum of eight visits; maximum of 12 visits).

The PMRG agreed that this approach has several potential benefits, including:

- Exploring bundled payments in private midwifery care offers the opportunity to assess the success of this model in a small, contained group of care providers, without affecting the majority of Australian midwifery funding.
- Bundled payments would align better with community and consumer expectations of continuity of midwifery care. These expectations are highlighted in the 2007 Commonwealth maternity services review (12).
- The cost of delivering maternity care could potentially be reduced.
- Midwifery continuity delivers better outcomes: fewer assisted births and birth interventions, fewer preterm births, increased breastfeeding rates and greater consumer satisfaction (5) and these benefits lead to cost savings at national and state levels.
- Bundling payments for midwifery care may lead more women to choose this model of care for their pregnancy, both because the payment model is easier to understand and because care is more affordable (assuming appropriate pricing).
- This in turn would lead to cost savings as more women complete their pregnancy care under a midwifery-led care model.

The PMRG noted the following risks:

- Bundled payments may increase complexity for women choosing or needing to change care provider.
- Bundled payments would be a departure from the fee-for-service nature of the MBS to date.
- Setting rebates appropriately across bundles of care is difficult and must ensure adequate access for women, adequate remuneration for providers and value for the health system.
- Most bundled payment models have been trialled in “clinical team” scenarios, with resultant improvements in continuity of care and clinical outcomes. The clinical gains may not be as great in a midwifery continuity of care model, where these attributes are already evident.

Summary

In summary, there are a number of benefits to be realised by negating the remaining structural and financial barriers to Medicare rebated midwifery care, thus increasing access to midwifery continuity of care models. In 2009, the Commonwealth maternity services review increased expectations of improved access to midwifery continuity of care. This has not occurred at the predicted rate (36; 33) as the barriers listed above have been underestimated and unaddressed. Women value supportive, respectful and relational care such as that provided by continuity of caregiver. Additionally, women wanting to birth safely and naturally, with lower intervention approaches consider Midwifery care as essential to achieving these objectives (12). Removal of the barriers to Midwifery continuity of care would enable an increase in uptake by women. There would be a reduction in interventions (fewer inductions of labour, pharmacological pain relief used during labour, decreased time in hospital) (5) and an increase in the proven health outcome benefits including increased breastfeeding rates, increased rates of normal vaginal birth, increased detection and treatment of mental health problems, decreased smoking during pregnancy, and a decrease in the rate of low birth weight in vulnerable populations (8).

The PMRG has taken many steps to reduce financial barriers to accessing the midwifery continuity of care model through the recommendations outlined in this report. Further financial considerations are covered below.

4.7.4 Participating Midwives Reference Group Stakeholder Impact Statement

Both consumers and participating midwives are expected to benefit from the recommendations in this report. In making its recommendations, the PMRG's primary focus was ensuring consumer access to high-quality maternity services. The PMRG also considered each recommendation's impact on participating midwives to ensure that it was fair and reasonable.

Consumers will benefit from the PMRG's recommendations through improved access to midwifery continuity of care models, higher quality of clinical services and increased choice, including:

- **Improved access to midwifery continuity of care:** The PMRG has recommended a series of schedule fee changes throughout the report. These will benefit consumers by reducing the currently high out-of-pocket fees incurred when accessing private midwifery care. The PMRG's recommendation to remove structural barriers limiting the number of participating midwives across Australia will facilitate increased access for consumers by building a workforce for this model. The PMRG's telehealth recommendations aim to increase access for rural and remote populations. The PMRG's recommendations will also increase the ability of Aboriginal Community Controlled Health Organisations to employ midwives across this sector and consider establishing birthing on country services in line with national guidelines. (45) This is crucial to providing a healthy start to life for mothers and babies and will help to close the gap in maternal and perinatal outcomes for Aboriginal and Torres Strait Islander families.
- **Higher quality clinical services:** The PMRG's recommendations on time-tiers for intrapartum items will reduce the risk of fatigue for participating midwives, increasing the quality of clinical services provided to consumers. The PMRG's recommendation restricting the use of maternity care plans will ensure that continuity of care is promoted.
- **Increased choice:** The PMRG's recommendation to facilitate home birthing under the MBS will benefit consumers by providing increased choice in the face of strong demand. These choices will provide safe birth options in line with clinical best-practice guidelines.

The PMRG's recommendations will benefit participating midwives by enshrining a more accurate representation of their work in the MBS, and increasing the financial viability of private midwifery care. More broadly, the recommendations will benefit midwives by providing increased choice in working models as private midwifery care becomes a financially and structurally viable option.

Consumers, midwives and the Australian health care system will benefit from overall increased investment in private midwifery continuity of care. These benefits will accrue from high-quality, cost-effective maternity outcomes that benefit families and the community.

5 Additional Taskforce Recommendations

Below are additional primary care centred recommendations from the Taskforce, independent from the GPPCCC and PCRGs.

5.1 Collaborative Arrangements

Taskforce Recommendation 1 - Review Collaborative Arrangements

The Taskforce strongly endorses collaborative arrangements in ensuring patient safety.

Collaborative Arrangements were established in 2010 and provide guidance on the details of collaborative arrangements, functions and the responsibilities of the NP involved in the collaboration, in relation to referrals, consultation and record keeping. The existing arrangements do not refer to scope of clinical practice.

The Taskforce recommends a review of Collaborative Arrangements to ensure safe and appropriate care, within the specified scope of clinical practice of the individual NP involved in the collaboration. Consideration should be given during the review to the responsibilities of the other parties in the collaboration to ensure that referrals are made according to the defined clinical scope of practice of the NP so that patients receive safe and appropriate care.

5.2 Scope of Practice

Taskforce Recommendation 2 - Establish scope of practice and credentialing frameworks for nurse practitioners

Throughout deliberations on the 14 recommendations presented by the NPRG, the Taskforce identified the lack of clarity regarding NP scope of practice as a major barrier to expansion of services through the MBS.

The Taskforce recommends NPs work together with their professional bodies to develop a clinical governance framework to be used as a guide for both the profession and others on an individual NP's scope of practice. This could be guided by the NMBA's professional practice framework and by reference to the framework for Rural and Isolated Practice Registered Nurses in Queensland and Victoria.

5.3 Alternative Models

Taskforce Recommendation 3 – Review alternative pathways to fund nurse practitioner services

The Taskforce notes the high level of variability in current NP operating models, including a variety of different funding arrangements that have a direct impact on the sustainability and innovation of the NP model of care. Exploration of alternative funding models outside the MBS is regarded as a more appropriate pathway.

The Taskforce recommends a review to canvass and assess alternative funding models to include practice/facility incentive payments, bundled payments, capitated, blended payments, or voluntary patent enrolment involving but not limited to the following:

- State and Territory Funded Health Services,
- PHNs,
- Health Care Homes,
- LHNs, and/or

- VPE model, and/or
- the MBS.

More information on Alternative Funding Models can be found in the 'Other Considerations' section of this report.

Taskforce Recommendation 4 - Investigate an alternative funding model for home birthing for patients with low-risk pregnancies

The Taskforce acknowledges the importance of safe, high quality care for all obstetric patients. Low risk deliveries may include birth in the home, under the care of an appropriately trained midwife working collaboratively with multidisciplinary support.

The Taskforce considers that the MBS is not the appropriate funding model or pathway to support collaborative quality patient care for low-risk home births and agrees the PMRG did not offer a suitable alternative solution.

Alternative funding models could be developed to support for low-risk home birthing services. If the Government was to explore this, the Taskforce recommends the following be considered:

a. Define appropriate collaborative arrangements to ensure patient safety

b. Undertake a thorough review into current access barriers, including:

   (i) definition of low risk

   (ii) accepted mechanisms to support patient safety and best practice and

   (iii) medical/professional indemnity insurance arrangements for participating midwives

c. Develop a definitive care framework supporting collaborative care arrangements between the patient, participating midwife, general practitioner obstetrician and/or specialist obstetrician for the duration of the pregnancy and at least two weeks post-partum.

d. Evaluate maternal and neonatal outcomes in the Australian health system.

5.4 Research

Taskforce Recommendation 5 – The Taskforce recommends development of a research agenda to identify research priorities and to inform any future policy changes or implementation

Some recommendations from the GPPCCC and PCRGs are supported by the Taskforce in principle, but the demonstration of need and the evidence presented in the rationales are insufficient or too weak for endorsement. At this time, these recommendations are best addressed through evaluating the research required to further develop their evidence-base.

A research agenda should be developed to prioritise research gaps.

Undertaking research will also provide a stronger evidence-base for any future work around these recommendations and for larger-scale projects such as the 10 Year Plan for Primary Care.

Taskforce Recommendation 6 – The Taskforce recommends development of a new research channel to fund, conduct, and publish research on how Australian healthcare can best benefit patients

Previously, questions arising from the MBS Review have been about medical science and have thus been diverted to MSAC or been resolved by expert opinion. Similarly, questions regarding pharmaceuticals stemming from reviews often focus on the drugs and technologies and are referred to the Pharmaceutical Benefits Advisory Committee (PBAC) or relevant experts.

Primary care, however, focuses mostly on human behaviours and clinical care.

The Taskforce agrees that broader and more in-depth research is needed to inform primary care in the Australian health system, with a focus on clinical benefits for patients.

The current main instruments for health research funding, the NHMRC and the MRFF, cannot provide adequate support for the amount of funding and type of research required.

- The NHMRC is Australia's peak funding body for medical research.
- The MRFF is a $20 billion long-term investment supporting Australian health and medical research.

The Taskforce recommends the development of a new research channel to fund, conduct, and publish research on how Australian healthcare can best benefit patients.

An example of a successful model to consider when developing this new research channel is the National Institute of Healthcare Research (NIHR) in the United Kingdom (UK). The NIHR research a wide range of clinical questions about care pathways and fund health and care research, providing the people, facilities, and technology that enable the research to thrive.

The NIHR works in partnership with the UK's National Health Service, universities, local governments, other research funders, patients and the public, to deliver and enable world-class research that transforms people's lives, promotes economic growth and advances science. The NIHR is primarily funded by the UK Department of Health and Social Care, but also receive UK Aid funding to support research for people in low- and middle-income countries.

6 Other considerations

6.1 Government announcements that align with GPPCCC recommendations

In April 2019, the Government announced funding of up to $448.5 million over three years to support enhanced primary care to patients through a VPE model. Australians over the age of 70 years of age will be able to voluntarily enter into an agreement with their general practice and receive more personalised, consistent and co-ordinated care, with usual services continuing to be rebated under Medicare. The GPPCCC report contains two draft recommendations supporting the introduction of a patient enrolment model (Phase 2, recs 2 and 3).

In December 2018, the Government announced funding of up to $98 million over four years, to introduce a new payment of a "flag fall" for GPs attending RACFs. This recommendation was based on clear stakeholder feedback both to the GPPCCC as well as to the DoH. The GPPCCC report contains a draft recommendation reflecting this (Phase 2, rec 9).

6.2 Telehealth

During deliberations on the primary care recommendations, the Taskforce agreed the nine telehealth related recommendations should be separated out and considered along with other outstanding telehealth recommendations from across the MBS review.

The Taskforce formed a Telehealth Working Group to assess the future of telehealth in the MBS and develop principles to help guide telehealth in the wider health system, including outside the MBS.

6.3 Medical Services Advisory Committee (MSAC)

The Taskforce notes some recommendations from the groups were better placed for submission to MSAC than for consideration through the MBS Review process, as the Taskforce does not have powers to change professional group access to existing MBS items or make recommendations on revenue use.

MSAC appraises amendments and reviews of existing services funded on the MBS or other programs (for example, blood products or screening programs) on an assessment of comparative safety, clinical effectiveness, cost-effectiveness, and total cost, using the best available evidence.

6.4 Alternative Funding Models and Pathways

Some recommendations were supported by the Taskforce in principle, but the changes or implementations proposed do not fit within the MBS and should be addressed through an alternative funding model or an alternative pathway.

Below are some examples of alternative pathways that may be considered for any future work around non-endorsed recommendations:

- **Health Care Homes:**

  A HCH is an existing general practice or ACCHS that further commits to a systematic approach to chronic disease management in primary care. This approach supports accountability for ongoing high-quality patient care. It uses an evidence-based, coordinated, multi-disciplinary model of care that aims to improve efficiencies and promote innovation in primary care services. The team approach and the bundled payment model provides GPs, nurses and other health care professionals greater flexibility to

shape care around an individual patient's needs and goals and encourages patients to participate in and direct their own care.

- **Incentive Programs (e.g. the Practice Incentive Program):**

  Through incentive payments, the PIP supports and promotes general practice activities that encourage continuing improvements, quality care, enhancing capacity and improving access and health outcomes for patients. The PIP is administered by DHS, on behalf of DoH. There are currently seven incentive payments:

  - eHealth (Digital Health) Incentive,
  - After Hours Incentive,
  - Rural Loading Incentive,
  - Teaching Payment,
  - Indigenous Health Incentive,
  - Procedural General Practitioner Payment, and
  - General Practitioner Aged Care Access Incentive.

- **Primary Health Networks:**

  PHNs are independent primary health care organisations, located throughout Australia. They are funded to undertake activities and commission services to address the prioritised primary health care needs of their communities and to improve efficiency, effectiveness and coordination of care.

6.5 Research Initiatives

Some recommendations were supported by the Taskforce in principle, but the changes or implementations proposed are better referred to an existing research platform.

Below are some examples of research pathways that may be considered for any future work around non-endorsed recommendations:

- **Indigenous Health Research Fund**
  - The Indigenous Health Research Fund is a national research initiative to improve the health of Aboriginal and Torres Strait Islander people via:
    - a 10-year research program funded by the MRFF supporting practical, innovative research into the best approaches to prevention, early intervention, and treatment of health conditions of greatest concern to Indigenous communities, and
    - focused research projects that fall into five key areas - guaranteeing a healthy start to life, improving primary health care, overcoming the origins of inequality in health, reducing the burden of disease, and addressing emerging challenges.

- **Medical Research Future Fund:**

  The MRFF is a $20 billion long-term investment supporting Australian health and medical research. The MRFF aims to transform health and medical research and innovation to improve lives, build the economy and contribute to health system sustainability.

- **Million Minds Mental Health Research Mission:**

The Million Minds Mental Health Research Mission will support research that addresses key national mental health priorities. It specifically encourages research to be translated into practice.

- **Preventative and Public Health Research initiative:**

  The Preventative and Public Health Research initiative's goal is to support targeted research on new ways to address risk factors for chronic and complex diseases in Australia.

- **Primary Health Care Activity – Indigenous Australians' Health Programme:**

  The Primary Health Care Activity (PHC Activity) is a component of the Indigenous Australians' Health Programme (IAHP), which aims to ensure Aboriginal and Torres Strait Islander people have access to effective health care services in urban, regional, rural and remote locations across the nation.

  The PHC Activity provides grant funding to a range of organisations including Aboriginal community controlled health organisations (ACCHOs), to support and deliver comprehensive, culturally appropriate primary health care services to Aboriginal and Torres Strait Islander people and provide system-level support to the Indigenous primary health care sector.

- **Primary Health Care Research initiative:**

  The Primary Health Care Research initiative supports health professionals and researchers with an interest in primary care to conduct research that is relevant to their needs. As a result, patients will experience improved, evidence-based primary health care in Australia.

  In the first instance, a $5 million open targeted call for research will be established in 2019–20 to fund projects that align with priorities currently being developed under the Primary Health Care 10 Year Plan.

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8 Glossary

8.1 Terms and Definitions

Table 3: Glossary – Terms and Definitions

TERM	DEFINITION / ACRONYM
Change	When referring to an item, 'change' describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
Co-claiming	MBS services claimed within an episode (same day, same facility, same patient)
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Episode	Same consumer, same facility, same day
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
New service	Describes when a new service has been recommended, along with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
"NK" items and "K" items	The letters used to denote "Capital sensitive items," where a reduced schedule fee applies to the imaging service provided on equipment that is 10 or more years old. This equipment must have been first installed in Australia 10 or more years ago, or in the case of imported pre-used equipment, must have been first manufactured 10 or more years ago. The one exception to this rule is where equipment is located in a remote area, when items with the letter "K" will apply.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
Other medical practitioner	A medical practitioner who is not a general practitioner, specialist or consultant physician, and who: (a) is registered under section 3GA of the Act, to the extent that the person is practising

TERM	DEFINITION / ACRONYM
	during the period in respect of which, and in the location in respect of which, they are registered, and insofar as the circumstances specified for paragraph 19AA(3)(b) of the Act apply; or (b) is covered by an exemption under subsection 19AB(3) of the Act; or (c) first became a medical practitioner before 1 November 1996.
Out of pocket (OOP)	Out-of-pocket payment. These are health care payments that consumers are expected to make themselves (i.e. an amount not rebated by Medicare).
Services average annual growth	The average growth per year, over five years to 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
Systematic Review	A literature review using systematic methods to collect information, data and available research findings. Following critical appraisal of the information, results are synthesised to provide a level of evidence on the effectiveness of the healthcare intervention.
Total benefits	Total benefits paid in 2014/15 unless otherwise specified.
Underserved	People who may not be able to gain entry to and receive care and services from the health care system. Factors influencing this ability include geographic, architectural, availability, transport and financial considerations, among others. Someone who is underserved may not necessarily receive less care, but they cannot receive it whenever or wherever they need it.

8.2 Acronyms and Names

Table 4: Glossary – Acronyms and Names

TERM	DEFINITION / ACRONYM
AASW	Australian Association of Social Workers
ACCHO	Aboriginal Community Controlled Health Organisations
ACCHS	Aboriginal Community Controlled Health Services
ACRRM	Australian College of Rural and Remote Medicine
ACT	Australian Capital Territory
AHPRA	Australian Health Practitioner Regulation Agency
AHRG	Allied Health Reference Group
AHS	Aboriginal Health Services
AMA	Australian Medical Association
ANMAC	Australian Nursing and Midwifery Accreditation Council
AQF	Australian Qualifications Framework
ASD	Autism spectrum disorder
Better Access	The Better Access initiative provides better access to mental health practitioners through Medicare
BMI	Body mass index
CAGR	Compound annual growth rate, or the average annual growth rate over a specified time period.
CCMP	Chronic care management plan
CND	Complex Neurodevelopmental Disorder
CT	Computed tomography
CTG	Cardiotocography
CVD	Cardiovascular disease

TERM	DEFINITION / ACRONYM
DHS	Australian Government Department of Human Services (now Services Australia)
DMMR	Domiciliary Medication Management Review
DoH	Australian Government Department of Health
DVA	Australian Government Department of Veteran Affairs
ED	Emergency Department
FASD	Foetal alcohol spectrum disorders
FI	Family intervention
FPS	Focused psychological therapies
FTE	Full-time equivalent
FY	Financial year
GDP	Gross domestic product
GP	General Practitioner
GPMP	GP Management Plan
GPPCCC	General Practice and Primary Care Clinical Committee
HCH	Health Care Homes
HCWA program	Helping Children with Autism program
HMR	Home Medicines Review
LHD	Local Hospital Districts
LHN	Local Hospital Networks
MBCT	Mindfulness-based cognitive therapy
MBS	Medicare Benefits Schedule
MBS Review	The Medicare Benefits Schedule Review
MHNIP	Mental Health Nurse Incentive Program
MHPT	Mental Health Treatment Plan
MHRG	Mental Health Reference Group
MIGA	Medical Insurance Group of Australia
Minister, The	Minister for Health
MMR	Medication management review
MRFF	Medical Research Future Fund
MRI	Magnetic resonance imaging
MSAC	Medical Services Advisory Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NASRHP	National Alliance of Self Regulating Health Professionals
National Law, The	Health Practitioner Regulation National Law 2009
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NDIS	National Disability Insurance Scheme

TERM	DEFINITION / ACRONYM
NHMRC	The National Health and Medical Research Council
NICE	National Institute for Health and Care Excellence
NMBA	Nursing and Midwifery Board of Australia
NP	Nurse practitioner
NPRG	Nurse Practitioner Reference Group
NRAS	National Registration and Accreditation Scheme
NSW	New South Wales
NT	Northern Territory
PARC	Principles and Rules Committee
PBS	Pharmaceutical Benefits Scheme
PCRG	Primary Care Reference Group
PDD	Pervasive development disorder
PHN	Primary Health Networks
PIP	Practice Incentive Program
PMRG	Participating Midwives Reference Group
PNIP	Practice Nurse Incentive Program
PSA	Pharmaceutical Society of Australia
P-SA	Prostate-specific antigen
PST	Problem-solving therapy
PTSD	Post-traumatic stress disorder
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Reference Group, The	The Aboriginal and Torres Strait Islander Health Reference Group
RMMR	Residential Medication Management Review
RN	Registered nurse
SA	South Australia
Taskforce, The	The MBS Review Taskforce
TCA	Team Care Arrangement
Working Group, The	The Primary Care Working Group
VII	Voluntary Indigenous Identifier
VPE	Voluntary Patient Enrolment
WHO	World Health Organization

Appendix A: List of Committee and Reference Group Members

All members of the Taskforce, Clinical Committees and Working Groups are asked to declare any conflicts of interest at the start of their involvement and are reminded to update their declaration periodically. It is noted that the majority of GPPCCC members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. GPPCCC members may perform services attracting benefits captured by items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Clinical Committee or Working Group and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review. Other declared interests are noted in the tables below.

Appendix A.1 General Practice and Primary Care Clinical Committee Members (Phase 1)

Table 5: GPPCCC Phase 1 – Members

Name	Position/Organisation	Declared interests
Prof Tim Usherwood (Chair)	• Head of the Department of General Practice, Sydney Medical School Westmead, University of Sydney • Visiting Professorial Fellow, the George Institute for Global Health • Clinical Academic, Westmead Hospital • GP, Sydney West Aboriginal Health Service	• Employee of The University of Sydney • Employee at Sydney West Aboriginal Health Service (MBS bulk-billing) • Health consumer entitled to MBS rebates • Board Member, Western Sydney Primary Health Network (WentWest Ltd) • Chair, Diagnostics Expert Advisory Panel, NPS MedicineWise
Prof Jon Adams	• Professor of Public Health • Australian Research Council (ARC) Future Fellow • Director of the Australian Research Centre in Complementary and Integrative Medicine (ARCCIM) at the University of Technology Sydney	• Nil
Ms Karen Booth	• Registered Nurse and Accredited Immuniser • Current President, Australian Primary Health Care Nurse Association • Primary Health Care Nurse and Nurse Manager in General Practice since 1998 • Member of the National Immunisation Committee, the Advisory Committee for Safety of Vaccines, GP Round Table 2015–2016 Member, Primary Health Care Advisory Group • Member of advisory groups for the Royal Australian College of General Practitioners (RACGP) and the Australian Commission on Safety and Quality in Health Care (ACQSHC)	• Nil

Name	Position/Organisation	Declared interests
Ms Thy Cao	• President of the New South Wales Branch of the Australian Physiotherapy Association • Current Chair of the University of Technology Sydney Physiotherapy Industry Advisory Board • Member, State Insurance Regulatory Authority (SIRA) Allied Health 2014–2016 • Member, Allied Health Practitioner Management Framework Review Working Party	• Australian Physiotherapy Association President (knowledge of submissions made)
Mr Peter Gooley	• Alzheimer's and Dementia Coach • Lead of a diabetes support group in the Hawkesbury area • Member, Community Board of Advice at the St John of God Hawkesbury Hospital, • Part of the Nepean Blue Mountains PHN (NBMPHN) Working Group, Hawkesbury • Member of the Community Advisory Committee, NBMPHN • Administrator, Memory People • President of local community centre management committee • Vice President, not-for-profit group encouraging and purchasing defibrillators, Hawkesbury local government area	• Involved with a Community Advisory Committee for Nepean Blue Mountains Primary Health Network
Dr Noel Hayman	• GP and Clinic Director, Inala Indigenous Health Service • Associate Professor, University of Queensland School of Medicine	• General Practitioner accessing MBS items • No work or shares in any corporate medical health settings
Prof Claire Jackson	• Director, Centre for Health System Reform and Integration • Professor in Primary Care Research • Past Chair, Brisbane North Primary Health Network • Past President, RACGP	• Clinical GP using MBS billing • Past Chair Brisbane North Primary Health Network • Director HCF
Prof Steve Jan	• Head of the Health Economics and Process Evaluation Program, the George Institute for Global Health • Professor, Sydney Medical School Associate, Menzies Centre for Health Policy and the Poche Centre for Indigenous Health Chief Investigator, NHMRC Australian Partnership Prevention Centre	• Nil
Dr Emma Kennedy	• Senior Lecturer, General Practice, Northern Territory Clinical School	• General Practitioner accessing MBS items

Name	Position/Organisation	Declared interests
		• Chair of the Northern Territory regional training program for GPs
A/Prof Caroline Laurence	• Associate Professor and Head of the School of Public Health, University of Adelaide • Health Services Researcher	• Director, Adelaide Unicare Pty Ltd.
Prof Lyn Littlefield	• Executive Director, Australian Psychological Society • Professor of Psychology, La Trobe University Chair, Allied Health Professions Australia • Chair, Mental Health Professions Australia	• Nil
Dr Elizabeth Marles	• Director, Hornsby-Brooklyn GP Unit Past President, RACGP • Member, Pharmaceutical Benefits Advisory Committee • Director, Therapeutic Guidelines	• Employee Staff Specialist GP with NSW Health, billing GP item numbers • Director, GP Synergy, training provider for GP training
Dr Ewen McPhee	• General Specialist in General Practice with the Australian Health Practitioner Regulation Agency (AHPRA), with Advanced Diploma of Obstetrics • Contractor to Central Highlands Health Pty Ltd—a social enterprise company chaired by the Deputy Mayor of the Central Highlands Regional Council (CHRH) and Chair of the Central Queensland Hospital and Health Service (CQHHS) • President of the Rural Doctors Association of Australia (RDAA) • Vice Chair of the Central Queensland, Wide Bay and Sunshine Coast Primary Health Network Central Queensland Clinical Council • Senior Fellow with Generalist Medical Training, James Cook University • Assistant Director of Medical Training General Practice Training Queensland (GPTQ) • Board Member of the Australian College of Rural and Remote Medicine (ACRRM)	• Registered General Specialist in General Practice with AHPRA, and hold an Advanced Diploma of Obstetrics. • Contractor to Central Highlands Health PTY LTD a social enterprise company chaired by the Deputy Major of Central Highlands Regional Council (CHRH) and Chair of the Central Queensland Hospital and Health Service (CQHHS). • The building I work from is the result of a GP Super clinics grant • Vice chair of the Central Queensland, Wide Bay and Sunshine Coast Primary Health Network CQ Clinical Council. • President of the Rural Doctors Association of Australia (RDAA). • Senior Fellow with Generalist Medical Training (GMT) James Cook University (JCU). • Assistant Director of Medical Training General Practice Training Queensland (GPTQ). • Board Member of the Australian College of Rural and Remote Medicine (ACRRM) • Member of the Queensland Liberal National Party
Ms Nadia Moffatt	• Non-Executive Director, Brain Injury SA (voluntary) • Non-Executive Director, Australian Communications Consumer Action Network (ACCAN) (voluntary) • Stroke Foundation, Consumer Council Member (voluntary)	• Non-executive director, Brain Injury SA (voluntary) • Non-executive director, Australian Communications Consumer Action Network (ACCAN) (voluntary) • Stroke Foundation, consumer council member (voluntary)

Name	Position/Organisation	Declared interests
	• Consumer Consultative Forum Member, Australian Communications Media Authority (ACMA)	• Consumer consultative Forum member, Australian Communications Media Authority (ACMA). • As a company director, I understand the importance of declaring any possible conflicts of interest and removing oneself from any situation that may pose a conflict of interest
Dr Mark Morgan	• Associate Professor, Bond University, Queensland • Associate GP, Eastbrooke Family Clinic, Burleigh Waters, Queensland • Member of the RACGP Expert Committee for Quality Care • Member of the MBS Review Diagnostic Medicine Clinical Committee and After Hours Working Group • Member of the Health Care Homes Implementation Advisory Committee • Member of the Digital Patient Safety Expert Advisory Group	• Nil
A/Prof Kathryn Panaretto	• Clinical Director, Gidgee Healing, Mt Isa GP, QUT Medical Centre • Adjunct Associate Professor, School of Medicine, University of Queensland • Adjunct Associate Professor, School of Medicine, James Cook University • Adjunct Associate Professor, Mt Isa Centre for Rural and Remote Health • Board Member, North West Health and Hospital Service, Queensland	• Nil
Mr Tim Perry	• Consultant Pharmacist • Member of the Western Sydney PHN Clinical Council	• Pharmacist working in General Practice and therefore have views supporting correct remuneration of both Pharmacists and GPs • Working in several practices that have Pathology collection services but I have no relationship with, or interest in, their work • Former traditional Chinese medicine practitioner, biased against MBS funding GPs doing acupuncture
Mr Gary Smith	• Practice Manager • Past National and New South Wales State President, Australian Association of Practice Management Ltd (AAPM) • Advisor to the Commonwealth Government on the management of health reform • Member of various advisory groups on behalf of AAPM • Hold Board positions with:	• Have Pathology collection centre on site at our practice

Name	Position/Organisation	Declared interests
	• Australian General Practice Accreditation Ltd (AGPAL; provides accreditation to general practices in Australia) • Quality in Practice, Chair (QIP; provides quality accreditation programs consistent with international standards to all sectors of business, both in Australia and internationally) • Nepean Blue Mountains Local Health District (LHD; appointed by the New South Wales Government to provide strategic oversight and monitor the LHD financial and operational performance under the state-wide performance framework, against the identified performance measures) • General Practice Workforce Tasmania (GPW; facilitates the recruitment and retention of General Practitioners and Allied Health in rural and remote areas in the state of Tasmania) • Surveyor with AGPAL and an International Surveyor with the International Society of Quality Health (ISQua)	
Prof Simon Willcock	• GP • Clinical Director of Primary Care and Wellbeing Services, • Macquarie University Chairman • Avant Mutual Group Member • Sydney North Primary Health Network Board	• I work in a practice that is part of the Macquarie University Integrate Health Sciences Centre, which incorporates the university-owned private hospital, my primary care clinic, Specialist and Allied Health clinics, Pathology services and a Diagnostic Imaging service. • The General Practice component has no financial arrangement with either the Radiology or Pathology services beyond our group association as described above. • Member of Health Insurer Board
Dr Steve Hambleton (Ex-Officio)	• GP • Past President of the Australian Medical Association • Past Chair of the Primary Health Care Advisory Group • Senior Responsible Owner within the Australian Digital Health Agency Member of the Atlas Advisory Group of the Australian Commission on Safety and Quality in Health Care	• Nil

Appendix A.1.1 Rendered Services Working Group Members

Table 6: GPPCCC Phase 1 – Rendered Services Working Group Members

Name	Position/Organisation
Prof Simon Willcock (Chair)	GPPCCC Member (see details in C.1)
Prof Jon Adams	GPPCCC Member (see details in C.1)
Ms Karen Booth	GPPCCC Member (see details in C.1)
Dr Emma Kennedy	GPPCCC Member (see details in C.1)
Prof Lyn Littlefield	GPPCCC Member (see details in C.1)
Prof Tim Usherwood	GPPCCC Member/Chair (see details in C.1)

Appendix A.1.2 Referred Services Working Group Members

Table 7: GPPCCC Phase 1 – Referred Services Working Group Members

Name	Position/Organisation
Mr Gary Smith (Chair)	GPPCCC Member (see details in C.1)
Ms Thy Cao	GPPCCC Member (see details in C.1)
Mr Peter Gooley	GPPCCC Member (see details in C.1)
Prof Claire Jackson	GPPCCC Member (see details in C.1)
Prof Lyn Littlefield	GPPCCC Member (see details in C.1)
Prof Tim Usherwood	GPPCCC Member/Chair (see details in C.1)

Appendix A.1.3 Diagnostic Imaging Working Group Members

Table 8: GPPCCC Phase 1 – Diagnostic Imaging Working Group Members

Name	Position/Organisation
Dr Ewen McPhee (Chair)	GPPCCC Member (see details in C.1)
Ms Thy Cao	GPPCCC Member (see details in C.1)
Prof Steve Jan	GPPCCC Member (see details in C.1)
Dr Elizabeth Marles	GPPCCC Member (see details in C.1)
A/Prof Kathryn Panaretto	GPPCCC Member (see details in C.1)
Prof Tim Usherwood	GPPCCC Member/Chair (see details in C.1)

Appendix A.1.4 Pathology Working Group Members

Table 9: GPPCCC Phase 1 – Pathology Working Group Members

Name	Position/Organisation
Dr Noel Hayman (Chair)	GPPCCC Member (see details in C.1)
Mr Peter Gooley	GPPCCC Member (see details in C.1)
A/Prof Caroline Laurence	GPPCCC Member (see details in C.1)
Dr Mark Morgan	GPPCCC Member (see details in C.1)
Mr Tim Perry	GPPCCC Member (see details in C.1)
Mr Gary Smith	GPPCCC Member (see details in C.1)
Prof Tim Usherwood	GPPCCC Member/Chair (see details in C.1)

Appendix A.2 General Practice and Primary Care Clinical Committee Members (Phase 2)

Table 10: GPPCCC Phase 2 – Members

Name	Position/Organisation	Declared interests
Prof Tim Usherwood (Chair)	• Head of the Department of General Practice, Sydney Medical School Westmead, University of Sydney • Visiting Professorial Fellow, the George Institute for Global Health • Clinical Academic, Westmead Hospital • GP, Sydney West Aboriginal Health Service	• Employee of The University of Sydney • Employee at Sydney West Aboriginal Health Service (MBS bulk-billing) • Health consumer entitled to MBS rebates • Board Member, Western Sydney Primary Health Network (WentWest Ltd) • Chair, Diagnostics Expert Advisory Panel, NPS MedicineWise
Ms Eleanor Chew (Phase 2 only)	• GP • Member, MBS Review Taskforce • member, Professional Service Review Committee • Board member, Australian Digital Health Agency • Board member, General Practice Training Queensland • Clinical Lead, Integrated Care, Sonic Clinical Services • Provost and Board member, RACGP Queensland • Member, AMA Queensland Council of General Practice • Member, Diagnostic Imaging Advisory Committee • Member, General Practice Mental Health Standards Collaboration	• GP accessing MBS items • Member, MBS Review Taskforce • member, Professional Service Review Committee • Board member, Australian Digital Health Agency • Board member, General Practice Training Queensland • Clinical Lead, Integrated Care, Sonic Clinical Services • Provost and Board member, RACGP Queensland • Member, AMA Queensland Council of General Practice • Member, Diagnostic Imaging Advisory Committee • Member, General Practice Mental Health Standards Collaboration

Name	Position/Organisation	Declared interests
Ms Rebecca James (Phase 2 only)	• Member of the Advisory Council of the Centre for Research into Clinical Effectiveness at Bond University.	• Member of Taskforce and the Colorectal, Ophthalmology, Optometry and Consumer Panel Clinical Committees • Member of the Advisory Council of the Centre for Research into Clinical Effectiveness at Bond University
Dr Walid Jammal (Phase 2 only)	• GP • Clinical Lecturer, Western Clinical School, Faculty of Medicine, University of Sydney • Conjoint Senior Lecturer, School of Medicine, Western Sydney University • Board Member of Western Sydney PHN • Member of GP Advisory Group, Agency for Clinical Innovation, NSW Ministry of Health • Member of Evaluation Sub-Committee, Medicare Services Advisory Committee	• GP accessing the MBS • Member of Diagnostic Medicine Clinical Committee and Diagnostic Imaging Clinical Committee, MBS Review • Member of Education and Training working group, and National Clinical Champion, Health Care Homes • Various review committees for Therapeutic Guidelines Ltd.
Prof Stephen Jan	• Head of the Health Economics and Process Evaluation Program, the George Institute for Global Health • Professor, Sydney Medical School • Associate, Menzies Centre for Health Policy and the Poche Centre for Indigenous Health • Chief Investigator, NHMRC Australian Partnership Prevention Centre	• Nil
Dr Emma Kennedy	• Senior Lecturer, General Practice, Northern Territory Medical Program, Flinders University • Chair of Board Northern Territory General Practice Education Pty Ltd	• General Practitioner accessing MBS items • Chair of the Northern Territory regional training program for GPs
Assoc Prof Caroline Laurence	• Associate Professor and Head of the School of Public Health, University of Adelaide • Health Services Researcher	• Director, Adelaide Unicare Pty Ltd.
Prof Lyn Littlefield	• Executive Director, Australian Psychological Society • Professor of Psychology, La Trobe University • Chair, Allied Health Professions Australia • Chair, Mental Health Professions Australia	• Nil
Dr Elizabeth Marles	• Director, Hornsby-Brooklyn GP Unit • Past President, RACGP • Member, Pharmaceutical Benefits Advisory Committee	• Employee Staff Specialist GP with NSW Health, billing GP item numbers • Director, GP Synergy, training provider for GP training

Name	Position/Organisation	Declared interests
	• Director, Therapeutic Guidelines	
Ms Helen Maxwell-Wright	• Director, Maxwell-Wright Associates Pty Ltd • President and Non Executive Director, OzChild Children Australia • Chair, State Leadership Group, JDRF • Chair, Monitoring Committee, Medicines Australia • ANZCA – • SIMGS Committee and Interview Panels • Safety & Quality Committee • Education Executive Management Committee • Faculty Pain Medicine, Training & Education Management Committee • AMC - Specialist Education Accreditation Committee	• Nil
Dr Ewen McPhee	• General Specialist in General Practice with the Australian Health Practitioner Regulation Agency (AHPRA), with Advanced Diploma of Obstetrics • Contractor to Central Highlands Health Pty Ltd—a social enterprise company chaired by the Deputy Mayor of the Central Highlands Regional Council (CHRH) and Chair of the Central Queensland Hospital and Health Service (CQHHS) • President of the Rural Doctors Association of Australia (RDAA) • Vice Chair of the Central Queensland, Wide Bay and Sunshine Coast Primary Health Network Central Queensland Clinical Council • Senior Fellow with Generalist Medical Training, James Cook University • Assistant Director of Medical Training General Practice Training Queensland (GPTQ) • Board Member of the Australian College of Rural and Remote Medicine (ACRRM)	• Registered General Specialist in General Practice with AHPRA, and hold an Advanced Diploma of Obstetrics. • Contractor to Central Highlands Health PTY LTD a social enterprise company chaired by the Deputy Major of Central Highlands Regional Council (CHRH) and Chair of the Central Queensland Hospital and Health Service (CQHHS). • The building I work from is the result of a GP Super clinics grant • Vice chair of the Central Queensland, Wide Bay and Sunshine Coast Primary Health Network CQ Clinical Council. • President of the Rural Doctors Association of Australia (RDAA). • Senior Fellow with Generalist Medical Training (GMT) James Cook University (JCU). • Assistant Director of Medical Training General Practice Training Queensland (GPTQ). • Board Member of the Australian College of Rural and Remote Medicine (ACRRM) • Member of the Queensland Liberal National Party
Dr Mark Morgan	• Associate Professor, Bond University, Queensland • Associate GP, Eastbrooke Family Clinic, Burleigh Waters, Queensland • Member of the RACGP Expert Committee for Quality Care	• Nil

Name	Position/Organisation	Declared interests
	• Member of the MBS Review Diagnostic Medicine Clinical Committee and After Hours Working Group • Member of the Health Care Homes Implementation Advisory Committee • Member of the Digital Patient Safety Expert Advisory Group	
Assoc Prof Kathryn Panaretto	• Clinical Director, Gidgee Healing, Mt Isa • GP, QUT Medical Centre • Adjunct Associate Professor, School of Medicine, University of Queensland • Adjunct Associate Professor, School of Medicine, James Cook University • Adjunct Associate Professor, Mt Isa Centre for Rural and Remote Health • Board Member, North West Health and Hospital Service, Queensland	• Nil
Mr Tim Perry	• Consultant Pharmacist • Member of the Western Sydney PHN Clinical Council	• Pharmacist working in General Practice and therefore have views supporting correct remuneration of both Pharmacists and GPs • Working in several practices that have Pathology collection services but I have no relationship with, or interest in, their work • Former traditional Chinese medicine practitioner, biased against MBS funding GPs doing acupuncture
Mr Gary Smith	• Practice Manager • Past National and New South Wales State President, Australian Association of Practice Management Ltd (AAPM) • Advisor to the Commonwealth Government on the management of health reform • Member of various advisory groups on behalf of AAPM • Hold Board positions with: • Australian General Practice Accreditation Ltd (AGPAL; provides accreditation to general practices in Australia) • Quality in Practice, Chair (QIP; provides quality accreditation programs consistent with international standards to all sectors of business, both in Australia and internationally) • Nepean Blue Mountains Local Health District (LHD; appointed by the New South Wales Government to provide strategic oversight and monitor the LHD financial and operational performance under the state-wide performance framework, against the identified performance measures)	• Have Pathology collection centre on site at our practice

Name	Position/Organisation	Declared interests
	• General Practice Workforce Tasmania (GPW; facilitates the recruitment and retention of General Practitioners and Allied Health in rural and remote areas in the state of Tasmania) • Surveyor with AGPAL and an International Surveyor with the International Society of Quality Health (ISQua)	
Prof Simon Willcock	• GP • Clinical Director of Primary Care and Wellbeing Services, • Macquarie University Chairman • Avant Mutual Group Member • Sydney North Primary Health Network Board	• I work in a practice that is part of the Macquarie University Integrate Health Sciences Centre, which incorporates the university-owned private hospital, my primary care clinic, Specialist and Allied Health clinics, Pathology services and a Diagnostic Imaging service. • The General Practice component has no financial arrangement with either the Radiology or Pathology services beyond our group association as described above. • Member of Health Insurer Board
Dr Steve Hambleton (Ex-Officio)	• GP • Past President of the Australian Medical Association • Past Chair of the Primary Health Care Advisory Group • Senior Responsible Owner within the Australian Digital Health Agency Member of the Atlas Advisory Group of the Australian Commission on Safety and Quality in Health Care	• Nil

Appendix A.2.1 Chronic Disease Management Working Group Members

Table 11: GPPCCC Phase 2 – Chronic Disease Management Working Group Members

Name	Position/Organisation
Prof Tim Usherwood (Chair)	GPPCCC Member/Chair (see details in A.2)
Dr Eleanor Chew	GPPCCC Member (see details in A.2)
Ms Rebecca James	GPPCCC Member (see details in A.2)
Dr Walid Jammal	GPPCCC Member (see details in A.2)
Prof Lyn Littlefield	GPPCCC Member (see details in A.2)
Mr Gary Smith	GPPCCC Member (see details in A.2)

Appendix A.2.2 Medication Management Working Group Members

Table 12: GPPCCC Phase 2 – Medication Management Working Group Members

Name	Position/Organisation
Mr Timothy Perry (Chair)	GPPCCC Member (see details in A.2)
Dr Emma Kennedy	GPPCCC Member (see details in A.2)
Dr Elizabeth Marles	GPPCCC Member (see details in A.2)
Ms Helen Maxwell-Wright	GPPCCC Member (see details in A.2)

Appendix A.2.3 Health Assessment Working Group Members

Table 13: GPPCCC Phase 2 – Health Assessment Working Group Members

Name	Position/Organisation
Prof Mark Morgan (Chair)	GPPCCC Member (see details in A.2)
A/Prof Noel Hayman	GPPCCC Member (see details in A.2)
Prof Claire Jackson	GPPCCC Member (see details in A.2)
Ms Rebecca James	GPPCCC Member (see details in A.2)
Prof Tim Usherwood	GPPCCC Member/Chair (see details in A.2)
Prof Simon Willcock	GPPCCC Member (see details in A.2)
Ms Thy Cao	GPPCCC Member (see details in A.2)

Appendix A.2.4 Consultation item Working Group Members

Table 14: GPPCCC Phase 2 – Consultation item Working Group Members

Name	Position/Organisation
A/Prof Kathryn Panaretto (Chair)	GPPCCC Member (see details in A.2)
Ms Karen Booth	GPPCCC Member (see details in A.2)
Dr Steve Hambleton	GPPCCC Member (see details in A.2)
Ms Rebecca James	GPPCCC Member (see details in A.2)

Name	Position/Organisation
Prof Stephen Jan	GPPCCC Member (see details in A.2)
Prof Caroline Laurence	GPPCCC Member (see details in A.2)
Dr Ewen McPhee	GPPCCC Member (see details in A.2)

Appendix A.3 Aboriginal and Torres Strait Islander Health Reference Group Members

Table 15: Aboriginal and Torres Strait Islander Health Reference Group – Members

Name	Position/Organisation	Declared interests
Assoc. Prof. Raymond Lovett (Chair)	• National Health and Medical Research Council (NHMRC) • Research Fellow and Program Leader for Aboriginal and Torres Strait Islander Health Epidemiology for Policy and Practice, Australian National University (ANU)	• Nil
Mr Shane Mohor	• CEO, Aboriginal Health Council of Australia	• Nil
Mr Karl Briscoe	• CEO, National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA)	• Represented NATSIHWA for stakeholder presentation
Ms Janine Mohamed	• CEO, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	• Nil
Mr Adrian Carson	• CEO, Institute for Urban Indigenous Health Ltd	• Nil
Ms Marilyn Morgan	• Member, Aboriginal and Torres Strait Islander Health Committee and National Advisory Council, Australian Physiotherapy Association; Director, National Health Leadership Forum; Member, Close the Gap Steering Committee	• Nil
Dr John Boffa	• Chief Medical Officer Public Health, Central Australian Aboriginal Congress, Aboriginal Corporation	• Nil
Mrs Sandy Robertson	• Consumer Representative; Has spent 20 years working in Aboriginal and Torres Strait Islander health delivering Medicare item training to health professionals	• Nil
Mr Nathan Agius	• Consumer Representative; Managing Director, An Open Heart is Good for Spirit Foundation	• Nil
Dr Noel Hayman (GPPCCC ex-officio)	• Clinical Director, Inala Indigenous Health Service; Associate Professor, University of Queensland School of Medicine	• Nil
Dr Tammy Kimpton (Taskforce ex-officio)	• General Practitioner	• Provider of MBS-rebated in-scope services

Name	Position/Organisation	Declared interests
Dr Lucas de Toca (Departmental advisor)	• Principal Advisor, Office of Health Protection, Australian Department of Health	• Nil

Appendix A.4 Allied Health Reference Group Members

Table 16: AHRG – Members

Name	Position/Organisation	Declared interests
Ms Merrin Prictor (Chair)	• Allied Health Consultant	• Nil
Mr Roland Balodis	• Departmental Advisor	• Nil
Ms Joanne Baumgartner	• Consumer Representative, Community Care Clinical Governance, eHealth Consumer Reference Group • Community Member, Tribunals, Australian Health Practitioners Regulation Agency • Assessor, National Alliance of Self Regulating Health Professionals, Audiology Australia	• Receives sitting fee for assessing applications to join the National Alliance of Self-Regulating Health Professionals (NASRHP) and, during the period 26 October 2017 to 30 June 2019, the Australian Health Practitioner Regulation Agency (AHPRA)
Ms Karen Booth	• Registered Nurse • General Practice Manager • President, Australian Primary Health Care Nurse Association	• Nil
Ms Petrina Burnett	• Consumer Representative, Breast Cancer Advisory Group, Cancer Australia, Breast Cancer Network Australia and Breast Cancer Trials Australia	• Nil
Mrs Christine Coop	• Occupational Therapist • Director, Enable Occupational Therapy in Mental Health	• Nil
Ms Michelle Funder	• Registered Osteopath; Director, Osteopathy Australia	• Nil
Mr Adrian Henry	• Registered Podiatrist	• Nil
Ms Liz Kellett	• Fellow of the Dietitians Association of Australia	• Nil
Ms Rosalind Knox	• Departmental Advisor	• Nil
Ms Jenney McConnell	• Registered Physiotherapist, private practice • Fellow of the Australian College of Physiotherapy	• Nil

Name	Position/Organisation	Declared interests
Dr Matthew McConnell	• Public Health Physician, Rural Support Service, SA Health • Taskforce Ex-Officio	• Nil
Assoc. Prof. Mark Morgan	• General Practitioner and GPPCCC Ex-Officio	• Associate Professor at Bond University, which teaches medical and allied health students. Chair of the RACGP Expert for Committee for Quality Care, providing advice to RACGP Board and CEO about quality and clinical matters. Collaborates with the Institute of Evidence Based Healthcare, which produces the Royal Australian College of General Practitioners (RACGP) Handbook of Non-Drug Interventions (HANDI).
Mr John Pearcy	• Audiologist in independent practice • Full member of Audiology Australia • Queensland representative on the Board of Audiology Australia • Member of Independent Audiologists Australia	• Board member of Audiology Australia (unpaid)
Mr Tim Perry	• Consultant Pharmacist • GPPCCC Ex-Officio	• Nil
Ms Caoimhe Scales	• Accredited Exercise Physiologist	• Nil
Dr Adam Smith	• Registered Chiropractor • Board Secretary, Chiropractors Association of Australia QLD	• Holds unpaid positions on several committees
Ms Robyn Stephen	• Certified practising Speech Pathologist • Director and Principle Clinician at Melbourne Child Development • Consult Speech Pathologist at Melbourne Paediatric Specialists	• Nil

Appendix A.5 Mental Health Reference Group Members

Table 17: MHRG – Members

Name	Position/Organisation	Declared interests
Dr Chris Mogan (Chair)	• Clinical Psychologist • Director, The Anxiety & OCD Clinic, Richmond, Victoria • Senior Fellow, University of Melbourne School of Psychological Sciences	• Provider of in-scope MBS items
Dr James Alexander	• Psychologist	• Provider of in-scope MBS items

Name	Position/Organisation	Declared interests
		• Member of the Australian Association of Psychologists Inc (AAPI)
Ms Voula Antoniadis	• Psychologist	• Provider of in-scope MBS items
Ms Leanne Clarke	• Clinical Psychologist; Director, Southside Health & Wellbeing	• Provider of in-scope MBS items; • Previously on the Australian Clinical Psychology Association (ACPA) Board • Previous advocacy for MBS clinical psychology items • Contributed to the original ACPA (2017) submission to the MBS Review
Mrs Christine Coop	• Occupational Therapist • Director, Enable Occupational Therapy in Mental Health	• Provider of in-scope MBS items
Mrs Amanda Curran	• Psychologist • Director, Family Matters Psychology Services	• Provider and consumer of MBS items • Family members are consumers of MBS items • Made a submission to the MBS Review • Previous advocacy work with Equality in Psychology and signed their Medicare review submission • Member of AAPI
Ms Jillian Harrington	• Clinical Psychologist, Southern Cross Psychology Pty Ltd • Director, Wentworth Healthcare Ltd (provider of the Nepean Blue Mountains Primary Health Network)	• Provider of in-scope MBS items; • Employer of providers of in-scope MBS items; • Member of the Australian Psychological Society, the Australian Association for Cognitive and Behaviour Therapy and the International Society for the Study of Trauma and Dissociation
Dr Caroline Johnson	• General Practitioner • Senior Lecturer, Department of General Practice, Melbourne Medical School, University of Melbourne	• Provider of in-scope MBS items; • Made a submission to the MBS Review as a Member of the Royal Australian College of General Practitioners Expert Committee – Quality Care
Dr Clive Jones	• Psychologist (Counselling Psychology and Sports and Exercise Psychology)	• Provider of FPS MBS items as a registered psychologist; Personal submission made to the MBS Review
Ms Karen King	• Counselling Psychologist at Brainbox Psychology Clinic	• Provider of in-scope MBS items
Assoc. Prof. Beth Kotze	• Executive Director, Mental Health, Western Sydney Local Health District	• Nil
Ms Janne McMahon OAM (Consumer representative)	• Chair, Private Mental Health Consumer Carer Network Australia	• Nil

Name	Position/Organisation	Declared interests
Ms Sonia Miller	• Nurse Practitioner and Credentialed Mental Health Nurse; • Director, MHNP Consulting; Chair, Australian College of Mental Health Nurses (ACMHN) • Mental Health Nurse Practitioners (MHNP) Special Interest Group	• Provider of Nurse Practitioner MBS items • Current Access to Allied Psychological Services (ATAPS) provider • Credentialed Mental Health Nurses (CMHN) provider under the Mental Health Nurse Incentive Program (MHNIP) until June 2018 • Mental Health Services Coordinator for GPDiv/ML/PHN until 2013 across ATAPS and MHNIP funding
Dr Ann Moir-Bussy	• Registered Counsellor and Psychotherapist	• Nil
Ms Joanne Muller (Consumer representative)	• Community Member	• Nil
Ms Wendy Northey	• Mental Health Consultant; Former Forensic Psychologist	• Nil
Dr Di Stow	• Counsellor • Accredited Clinical Registrant • Accredited Mental Health Practitioner • Accredited Supervisor, • Accredited Surrogacy Counsellor • President, Psychotherapy and Counselling Federation of Australia	• Nil
Ms Julianne Whyte	• Accredited Mental Health Social Worker • Chief Executive Officer, Amaranth Foundation • Member of the Australian Association of Social Workers (AASW) Palliative Care Social Work Practice Group • Social Work in Private Practice Group • Accredited Mental Health Social Work Practice Group	• Provider of in-scope MBS items • Contributed to the AASW response to the Draft Mental Health Reference Group Report
Mr Bill Buckingham (Department advisor)	• Technical Advisor (Mental Health) to Department of Health	Nil. Non-voting member
Dr Lee Gruner (ex-officio member)	• Member of the Medicare Benefits Schedule Review Taskforce	Nil Non-voting member

Appendix A.6 Nurse Practitioner Reference Group Members

Table 18: NPRG – Members

Name	Position/Organisation	Declared interests
Assoc. Professor. Tom Buckley (Chair)	• Academic Lead, Research Education, Susan Wakil School of Nursing and Midwifery, Faculty of Medicine and Health, University of Sydney • Chair of the Australian Nursing and Midwifery Accreditation Council NP Accreditation Committee	• Nil
Ms Julianne Bryce	• Registered Nurse • Senior Federal Professional Officer of the Australian Nursing and Midwifery Federation	• Nil
Professor. Andrew Cashin	• Mental Health NP • Professor of Nursing, Southern Cross University	• Nil
Ms Julie Davey (Consumer representative)	• Member, Stroke Foundation Consumer Council • Associate Fellow, Australasian College of Health Service Managers	• Nil
Dr Christopher Helms	• Primary Healthcare NP, Bridging Healthcare	• Member of the Healthcare Homes Implementation Advisory Group • Member of the NP Advisory Committee for the MBS Review Taskforce • Provider of MBS-rebated in-scope services • Practitioner member of the Nursing and Midwifery Board of Australia
Mr Peter Jenkin	• Palliative Care NP	• Provider of MBS-rebated in-scope services
Ms Penelope Lello (Consumer representative)	• Director, Deepening Change • Co-Chair and Committee roles held Australian Medical Council • South Australian Health and Medical Research Institute • Department of Health and Wellbeing SA Allied Health Clinical Governance Committee, and Women's and Children's Hospital Network	• Nil
Ms Lesley Salem	• NP, Primary Health, Indigenous Health	Nil
Dr Jane Truscott	• NP • Senior Lecturer at the School of Nursing, Midwifery and Social Sciences, CQ University • Chairperson of the Rural Locum Assistance Program (LAP) Board	• Employed at Aspen Medical (intermittently) • Chair of Rural LAP
Ms Karen Booth (GPPCCC ex-officio member)	• Registered Nurse and General Practice Manager • President, Australian Primary Health Care Nurse Association	• Nil

Name	Position/Organisation	Declared interests
Adj. Professor. Steve Hambleton (Taskforce ex-officio member)	• Former Federal President of the Australian Medical Association • Chair of the Primary Health Care Advisory Group	Nil
Ms Liza Edwards (Department Advisor)	• Principal Nurse Advisor, Department of Health	• Nil

Appendix A.7 Participating Midwives Reference Group Members

Table 19: PMRG – Members

Name	Position/Organisation	Declared interests
Ms Donna Garland	• Operations Director, Women's and Newborn Health, Westmead Hospital	• Nil
Prof. Jonathan Morris	• Professor of Obstetrics and Gynaecology, The University of Sydney • Maternal Foetal Medicine Specialist, Royal North Shore Hospital, Northern Sydney Local Health District (NSLHD), Sydney	• Nil
Prof. Sue Kildea	• Professor of Midwifery, Director of the Midwifery Research Unit, Mater Research Institute University of Queensland, UQ School of Nursing, Midwifery and Social Work, Mothers, Babies and Women's Services, Mater Health Service	• Nil
Ms Elizabeth Wilkes	• Registered midwife • Endorsed midwife • Managing Director, My Midwives	• Midwife using Medicare items in private practice
Ms Marijke Eastaugh	• Registered midwife • Endorsed midwife • International Board-Certified Lactation Consultant	• Midwife using Medicare items in private practice
Ms Julianna Badenoch	• Registered Nurse and midwife	• Nil
Dr Gwendoline Burton	• Chair, Royal Australian College of General Practitioners (RACGP) Antenatal and Postnatal Care Network	• Nil
Ms Alecia Staines	• Director, Maternity Consumer Network	• Nil
Ms Penelope Lello	• Director, Deepening Change;	• Nil

Name	Position/Organisation	Declared interests
	• Committee roles held at: South Australian Health and Medical Research Institute; Department for Health and Wellbeing South Australia; Central Adelaide Local Health Network (CALHN) Allied Health Clinical Governance; and the Women's and Children's Hospital Network	
Dr Bev Rowbotham (Taskforce ex-officio)	• Associate Professor of Pathology, University of Queensland	• Nil
Adj. Prof. Debra Thoms (Dept. medical officer)	• Chief Nursing and Midwifery Officer, Department of Health	• Nil
Dr Ewen McPhee (GP Committee ex-officio)	• General Practitioner and President of Rural Doctors Association of Australia	• Nil

Appendix B: Full List of In-scope items

Appendix B.1 GPPCCC Phase 1 – In-scope items

Table 20: GPPCCC Phase 1 – In-scope items

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
173	Attendance at which acupuncture is performed by a Medical Practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed.	$21.65	43,807	$1,142,800	-11.6%
193	Professional attendance by a GP who is a qualified medical acupuncturist, at a place other than a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	$37.05	373,525	$14,802,075	0.1%
195	Professional attendance by a GP who is a qualified medical acupuncturist, on 1 or more patients at a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care;	The fee for item 193, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193	6	$284	-31.6%

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
	for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	plus $2.00 per patient.			
197	Professional attendance by a GP who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 20 minutes and including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	$71.70	105,964	$7,918,635	6.7%
199	Professional attendance by a GP who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 40 minutes and including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	$105.55	9,031	$1,035,954	6.8%

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
30026	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$52.20	99,359	$4,314,561	0.7%
30029	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm in length), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$90.00	25,615	$1,928,537	-1.3%
30032	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), superficial (Anaes.)	$82.50	36,927	$2,566,887	-0.6%
30035	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), involving deeper tissue (Anaes.)	$117.55	9,116	$900,748	-3.3%
30038	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$90.00	8,010	$597,866	1.3%
30041 (G)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$144.00	5,985	$724,826	-0.2%
30042 (S)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$185.60	166	$21,451	0.2%
30045 (S)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), superficial (Anaes.)	$117.55	1,285	$127,523	-1.4%
30048 (G)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.)	$149.75	947	$120,799	-4.6%
30049 (S)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.)	$185.60	40	$5,433	-4.7%

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
2100	Level A - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; (B) or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies.	$22.90	633	$14,525	-
2122	Level A - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion each patient.	$0.00	15	$774	-
2125	Level A - telehealth attendance at a residential aged care facility. A professional attendance by a Medical Practitioner (not being a service to which any other item applies) lasting at least 5 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit) and who is participating in a video consultation with a specialist or Consultant Physician, on 1 occasion - each patient.	$0.00	2	$139	-
2126	Level B - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or Consultant Physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (a) an Aboriginal medical service; or (b) an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the Act applies.	$49.95	14,161	$707,590	-

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
2137	Level B - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or Consultant Physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient.	$0.00	65	$5,173	-
2138	Level B - telehealth attendance at residential aged care facility. Professional attendance of less than 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or Consultant Physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient.	$0.00	86	$5,942	-
2143	Level C - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a Medical Practitioner who provides clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies.	$96.85	12,844	$1,244,213	-
2147	Level C - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion each patient.	$0.00	174	$21,409	-
2179	Level C - a professional attendance by a Medical Practitioner (not being a service to which any other items applies) lasting at least 20 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is (a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit) or b) at consulting rooms situated within such a complex where the patient	$0.00	70	$9,299	-

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
	is a resident of the aged care service (excluding accommodation in a self-contained unit) and who is participating in a video consultation with a specialist or Consultant Physician, on 1 occasion - each patient.				
2195	Level D - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or Consultant Physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies.	$142.50	5,770	$822,256	-
2199	Level D - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion each patient.	$0.00	76	$12,778	-
2220	Level D - telehealth attendance at residential aged care facility. A professional attendance by a Medical Practitioner (not being a service to which any other item applies) lasting at least 40 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit);and who is participating in a video consultation with a specialist or Consultant Physician, on 1 occasion - each patient.	$0.00	61	$11,012	-

Appendix B.2 GPPCCC Phase 2 – In-scope items

Table 21: GPPCCC Phase 2 – In-scope items

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
715	Professional attendance by a medical practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent	$212.25	217,678	$46,202,133	17.65%
10950	Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner for chronic and complex care needs	$62.25	3,178	$168,275	31.22%%
81310	Audiology health service	$62.25	1,197	$63,381	122.40%
81330	Occupational therapy health service	$62.25	2,361	$126,623	106.42%
81300	Aboriginal and Torres strait islander health service	$62.25	14,792	$783,236	64.66%
81315	Exercise physiology health service	$62.25	3,063	$162,346	60.01%
81345	Chiropractic health service	$62.25	1,675	$88,548	53.43%
81355	Psychology health service	$62.25	1,419	$76,191	52.33%
81360	Speech pathology health service	$62.25	3,937	$210,978	50.97%
81335	Physiotherapy health service	$62.25	11,487	$609,270	43.07%
81340	Podiatry health service	$62.25	8,662	$458,835	35.91%
81320	Dietetics health service	$62.25	3,824	$202,549	33.85%
81350	Osteopathy health service	$62.25	222	$12,041	29.48%
81325	Mental health service	$62.25	300	$16,313	27.80%
81305	Diabetes education health service	$62.25	2,030	$107,489	22.80%
10984	Telehealth Support Service by a practice nurse or Aboriginal health worker or Aboriginal and Torres Strait Islander health practitioner provided on behalf of, and under the supervision of, a medical practitioner at a Residential Aged Care Facility (RACF)	$32.40	113	$3,659	86.56%

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
10983	Telehealth Support Service: Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient	$32.40	7,815	$253,280	53.47%
10987	Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment	$24.00	222,730	$5,345,518	51.83%
10997	Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner under the supervision of a medical practitioner	$12.00	1,840,258	$22,084,311	28.54%
10988	Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner	$12.00	11,289	$135,468	26.43%
10989	Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner	$12.00	12,262	$147,144	25.66%

Appendix B.3 Aboriginal and Torres Strait Islander Health – In-scope items

Table 22: Aboriginal and Torres Strait Islander Health Reference Group – In-scope items

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
715	Professional attendance by a medical practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent	$212.25	217,678	$46,202,133	17.65%
10950	Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner for chronic and complex care needs	$62.25	3,178	$168,275	31.22%%
81310	Audiology health service	$62.25	1,197	$63,381	122.40%
81330	Occupational therapy health service	$62.25	2,361	$126,623	106.42%
81300	Aboriginal and Torres strait islander health service	$62.25	14,792	$783,236	64.66%
81315	Exercise physiology health service	$62.25	3,063	$162,346	60.01%

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
81345	Chiropractic health service	$62.25	1,675	$88,548	53.43%
81355	Psychology health service	$62.25	1,419	$76,191	52.33%
81360	Speech pathology health service	$62.25	3,937	$210,978	50.97%
81335	Physiotherapy health service	$62.25	11,487	$609,270	43.07%
81340	Podiatry health service	$62.25	8,662	$458,835	35.91%
81320	Dietetics health service	$62.25	3,824	$202,549	33.85%
81350	Osteopathy health service	$62.25	222	$12,041	29.48%
81325	Mental health service	$62.25	300	$16,313	27.80%
81305	Diabetes education health service	$62.25	2,030	$107,489	22.80%
10984	Telehealth Support Service by a practice nurse or Aboriginal health worker or Aboriginal and Torres Strait Islander health practitioner provided on behalf of, and under the supervision of, a medical practitioner at a Residential Aged Care Facility (RACF)	$32.40	113	$3,659	86.56%
10983	Telehealth Support Service: Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient	$32.40	7,815	$253,280	53.47%
10987	Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment	$24.00	222,730	$5,345,518	51.83%
10997	Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner under the supervision of a medical practitioner	$12.00	1,840,258	$22,084,311	28.54%
10988	Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner	$12.00	11,289	$135,468	26.43%
10989	Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner	$12.00	12,262	$147,144	25.66%

Appendix B.4 Allied Health – In-scope items

Table 23: AHRG – In-scope items

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
10951	Diabetes education service to person with chronic condition under a care plan >20 mins	62.25	92,688	$4,937,916	5.0%
10952	Audiology education service to person with chronic condition under a care plan >20 mins	62.25	1,868	$105,655	12.4%
10953	Exercise physiology service to person with chronic condition under a care plan >20 mins	62.25	279,323	$14,908,153	20.9%
10954	Dietetics service to person with chronic condition under a care plan >20 mins	62.25	414,899	$22,172,147	10.5%
10956[7]	Mental health service to person with chronic condition under a care plan >20 mins	62.25	5,726	$332,292	9.6%
10958	Occupational therapy service to person with chronic condition under a care plan >20 mins	62.25	69,219	$4,158,674	16.1%
10960	Physiotherapy service to person with chronic condition under a care plan >20 mins	62.25	2,197,772	$117,264,835	16.6%
10962	Podiatry service to person with chronic condition under a care plan >20 mins	62.25	3,009,782	$159,800,577	12.8%
10964	Chiropractic service to person with chronic condition under a care plan >20 mins	62.25	354,501	$18,775,603	14.3%
10966	Osteopathy service to person with chronic condition under a care plan >20 mins	62.25	165,201	$8,876,660	13.9%
10968	Psychology service for person with chronic condition under a care plan, >20 mins	62.25	28,390	$2,131,564	23.1%
10970	Speech pathology service to person with chronic condition under a care plan >20 mins	62.25	156,592	$9,025,165	7.3%
81100	Assessment of suitability for group diabetes education service >45 mins	79.85	1,871	$127,085.65	8.30%
81105	Diabetes education group service; 2-12 patients, >=60 mins	19.90	1,135	$19,238.25	-13.29%
81110	Assessment of suitability for group exercise physiology service >45 mins	79.85	10,440	$709,080.94	12.86%
81115	Exercise physiology group service; 2-12 patients, >=60 mins	19.90	55,089	$935,701.55	15.14%
81120	Assessment of suitability for group dietetics service >45 mins	79.85	1,200	$81,489.70	-11.16%

[7] Also in the Mental Health Reference Group's area of responsibility.

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
81125	Dietetics group service; 2-12 patients, >=60 mins	19.90	2,649	$44,905.45	-12.11%
82000	Psychology service provided to a child (<13 years) by eligible psychologist, >=50 mins	99.75	10,258	$1,300,698.90	10.16%
82005	Speech pathology service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	4,697	$506,641.70	8.21%
82010	Occupational therapy service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	1,146	$110,386.60	9.11%
82015	Psychology service provided to a child (<15 years), for treatment of PDD or an eligible disability by eligible psychologist, >=50 mins	99.75	4,645	$540,563.42	1.70%
82020	Speech pathology service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	20,016	$1,741,776.00	2.41%
82025	Occupational therapy service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	10,154	$928,442.45	10.15%
82030	Audiology, optometry, orthoptic or physiotherapy service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	533	$40,521.53	70.49%
82035	Audiology, optometry, orthoptic or physiotherapy provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	1,245	$118,236.05	30.81%

Appendix B.5 Mental Health – In-scope items

Table 24: MHRG – In-scope items

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17
170	Family Group Therapy (excluding psychiatrist) >=1 hour, 2 patients	117.55	9,010	1,186,406
171	Family Group Therapy (excluding psychiatrist) >=1 hour, 3 patients	123.85	1,542	204,109
172	Family Group Therapy (excluding psychiatrist) >=1 hour, 4+ patients	150.70	471	70,080
2700	Preparation of GP Mental Health Treatment Plan, (medical practitioner without mental health training) >20 to <40 mins	71.70	154,195	11,084,468

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17
2701	Preparation of GP Mental Health Treatment Plan, (medical practitioner without mental health training) >40 mins	105.55	65,974	6,970,266
2712	Review of a GP mental health treatment plan or a Psychiatrist Assessment and Management Plan	71.70	456,706	32,915,081
2713	Attendance in relation to mental disorder, including taking documentation, >20 mins	71.70	1,674,946	120,445,474
2715	Preparation of a GP mental health treatment plan, (medical practitioner with mental health training), >20 to <40 mins	91.05	734,815	67,072,887
2717	Preparation of a GP mental health treatment plan, (medical practitioner with mental health training), >=40 mins	134.10	279,234	37,484,095
2721	Consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >30 to <40 mins	92.75	3,916	364,226
2723	Non-consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >30 to <40 mins	92.75, plus $25.95 divided by the number of patients seen, up to a max of 6	20	2,374
2725	Consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >=40 mins	132.75	28,321	3,860,772
2727	Non-consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >=40 mins	132.75, plus $25.95 divided by the number of patients seen, up to a max of 6 patients	162	25,024
4001	Attendance for non-directive pregnancy support counselling (medical practitioner registered with the Chief Executive Medicare), >20 mins	4001: Attendance for non-directive pregnancy support counselling (medical practitioner registered with the Chief Executive Medicare), >20 mins	76.60	13,414
10956	Mental Health service for person with chronic condition under a care plan, >20 mins	62.25	5,726	332,292
10968	Psychology service for person with chronic condition under a care plan, >20 mins	62.25	28,390	2,131,564
80000	Assessment and therapy by clinical psychologist (consulting rooms), >30 to <50 mins	99.75	14,618	1,254,655
80005	Assessment and therapy by clinical psychologist (non-consulting rooms), >30 to <50 mins	124.65	1,107	117,719

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17
80010	Assessment and therapy by clinical psychologist (consulting rooms), >=50 mins	146.45	2,092,967	267,332,018
80015	Assessment and therapy by clinical psychologist (non-consulting rooms), >=50 mins	171.35	38,605	5,772,732
80020	Group therapy, 6-10 patients: Therapy by clinical psychologist, >=60 mins	37.20	15,355	590,441
80100	Attendance for focussed psychological strategies services by psychologist (consulting rooms), >20 to <50 mins	70.65	31,592	1,954,150
80105	Attendance for focussed psychological strategies services by psychologist (non-consulting rooms), >20 to <50 mins	96.15	2,652	219,066
80110	Attendance for focussed psychological strategies services by psychologist (consulting rooms), >50 mins	99.75	2,493,291	218,621,512
80115	Attendance for focussed psychological strategies services by psychologist (out of rooms), >50 mins	125.30	154,851	16,771,822
80120	Group therapy, 6-10 patients: focussed psychological strategies services by psychologist, >=60 mins	25.45	21,450	587,021
80125	Attendance for focussed psychological strategies services by occupational therapist (consulting rooms), >20 to <50 mins	62.25	5,099	317,523
80130	Attendance for focussed psychological strategies services by occupational therapist (non-consulting rooms), >20 to <50 mins	87.70	998	81,349
80135	Attendance for focussed psychological strategies services by occupational therapist (consulting rooms), >50 mins	87.95	50,572	4,200,419
80140	Attendance for focussed psychological strategies services by occupational therapist (non-consulting rooms), >50 mins	113.35	11,040	1,143,529
80145	Group therapy, 6-10 patients: focussed psychological strategies services by occupational therapist, >=60 mins	22.35	1,613	60,129
80150	Attendance for focussed psychological strategies services by social worker (consulting rooms), >20 to <50 mins	62.25	2,782	150,046
80155	Attendance for focussed psychological strategies services by social worker (non-consulting rooms), >20 to <50 mins	87.70	2,055	153,333

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17
80160	Attendance for focussed psychological strategies services by social worker (consulting rooms), >50 mins	87.95	253,143	19,565,965
80165	Attendance for focussed psychological strategies services by social worker (non-consulting rooms), >50 mins	113.35	52,110	5,032,336
80170	Group therapy, 6-10 patients: focussed psychological strategies services by social worker, >=60 mins	22.35	2,406	47,008
81000	Non-directive pregnancy support counselling service by eligible psychologist >=30 mins	73.15	209	16,474
81005	Non-directive pregnancy support counselling service by eligible social worker >=30 mins	73.15	125	7,813
81010	Non-directive pregnancy support counselling service by eligible mental health nurse >=30 mins	73.15	460	34,110
82000	Psychology service provided to a child (<13 years) by eligible psychologist, >=50 mins	99.75	10,258	1,300,699
82015	Psychology service provided to a child (<15 years), for treatment of PDD or an eligible disability by eligible psychologist, >=50 mins	99.75	4,645	540,563
82005	Speech pathology service provided to a child (<13 years) for diagnosis or PDD/disability treatment, >=50 mins	87.95	4,697	506,642
82010	Occupational therapy service provided to a child (<13 years) for diagnosis or PDD/disability treatment, >=50 mins	87.95	1,146	110,387
82020	Speech pathology service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	20,016	1,741,776
82025	Occupational therapy service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	10,154	928,442
82030	Audiology, optometry, orthoptic or physiotherapy service provided to a child (<13 years) for diagnosis or PDD/disability treatment, >=50 mins	87.95	533	40,522
82035	Audiology, optometry, orthoptic or physiotherapy provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	1,245	118,236

Appendix B.6 Nurse Practitioners – In-scope items

Table 25: NPRG – In-scope items

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
82200	Professional attendance by a participating NP for an obvious problem characterised by the straightforward nature of the task	9.60	53,990	$442,762.00	85.71%
82205	Professional attendance by a participating NP lasting less than 20 minutes	20.95	120,414	$2,152,151.20	23.74%
82210	Professional attendance by a participating NP lasting at least 20 minutes	39.75	133,334	$4,523,977.20	50.76%
82215	Professional attendance by a participating NP lasting at least 40 minutes	58.55	109,966	$5,547,413.10	63.87%
82220	A professional attendance lasting less than 20 minutes that requires the provision of clinical support to a patient who is participating in a video consultation with a specialist or consultant physician	28.30	109	$2,610.95	55.47%
82221	A professional attendance lasting at least 20 minutes that requires the provision of clinical support to a patient who is participating in a video consultation with a specialist or consultant physician	53.70	244	$11,138.60	161.38%
82222	A professional attendance lasting at least 40 minutes that requires the provision of clinical support to a patient who is participating in a video consultation with a specialist or consultant physician	78.95	593	$39,819.95	105.96%
82223	A professional attendance lasting less than 20 minutes that requires the provision of clinical support to a patient at a RACF who is participating in a video consultation with a specialist or consultant physician	28.30	0	$0	N/A
82224	A professional attendance lasting at least 20 minutes that requires the provision of clinical support to a patient at a RACF who is participating in a video consultation with a specialist or consultant physician	53.70	5	$228.25	20.11%
82225	A professional attendance lasting at least 40 minutes that requires the provision of clinical support to a patient at a RACF who is participating in a video consultation with a specialist or consultant physician	78.95	82	$5,506.30	82.96%

Appendix B.7 Participating Midwives – In-scope items

Table 26: PMRG – In-scope items

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes	53.40	3,883	177,829	30.0%
82105	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.	32.30	12,154	349,024	21.5%
82110	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	53.40	24,209	1,156,532	36.2%
82115	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks	319.00	6,235	1,706,909	49.3%
82120	Management of confinement for up to 12 hours, including delivery (if undertaken)	753.30	530	299,405	61.7%
82125	Management of confinement for in excess of 12 hours, including delivery where performed; when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)	753.30	137	77,405	114.7%
82130	Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery	53.40	2,547	110,530	35.4%
82135	Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery	78.50	28,844	2,004,481	48.3%
82140	Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby	53.40	989	48,100	33.2%
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	28.30	1	24	-24.2%
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	53.70	2	91	-16.7%

item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	78.95	15	1,007	N/A