



Medicare Benefits Schedule Review Taskforce

Post Consultation Report from the Aboriginal and Torres Strait Islander Health Reference Group

2019



Important note

This report does not constitute the final position on these items, which is subject to:

- Consideration by the MBS Review Taskforce;

Then

- Consideration by the Minister for Health; and
- Government.



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1 Executive summary

1.1 Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers 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 The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.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 each of these four key goals:

- Affordable and universal access.
- Best-practice health services.
- Value for the individual patient.
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees, primary care reference groups (PCRGs) and working groups.

1.2 Review of the Aboriginal and Torres Strait Islander Health MBS items

The Aboriginal and Torres Strait Islander Health Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The PCRGs provide recommendations to the Taskforce in a review report. Once endorsed by the Taskforce, the review reports are released for targeted stakeholder consultation. The Taskforce then considers the revised review reports, which include stakeholder feedback, before making recommendations to the Minister for consideration by Government.

1.3 Main themes

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



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

1.4 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 GP Management Plan (GPMP) with team care arrangements (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).

1.5 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.

1.6 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 Nurse Practitioner Reference Group and the Participating Midwives Reference Group to develop telehealth solutions for GP-to-patient services.

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

Appendices D and E set out the Reference Group's response to issues raised and/or referred to it by the Renal Medicine Clinical Committee and the GPPCCC, respectively.

1.7 Consumer impact

The Reference Group 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 Reference Group's recommendations will benefit consumers in the following ways:

- **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, enhance social and emotional well-being support, promote cultural safety for all health providers and to investigate the future role of non-registered Aboriginal and Torres Strait Islander health professionals all support more culturally safe and appropriate services.



- **Investment 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) Directions for state and territory clinics is reinvested into those services, all support more effective and accessible health services.

These benefits would accrue from high-quality, cost-effective prevention and treatment outcomes that benefit 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.

1.8 Next steps

This report from the Reference Group is being released for stakeholder feedback simultaneously with the reports from the other reference groups.

This is to enable stakeholders to examine the issues within the overall context of primary care. In this regard the Phase One and Phase Two reports of the GPPCCC are an important part of the examination of primary care across the MBS. The two reports were released for stakeholder feedback in December 2018.

The Reference Group will consider feedback from stakeholders then provide recommendations to the Taskforce in a finalised Review Report.

The Taskforce considers the Review Reports from the reference groups and any stakeholder feedback before making recommendations, if required, to the Minister for consideration by Government.



2 About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

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).
- Subsidised health professional services listed on the MBS.

2.2 What is 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.

2.3 What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The MBS Review is clinician-led, and there are no targets for savings attached to the review.

2.3.1 What are the goals of the Taskforce?

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

- **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 to many specialist services remains problematic, with some rural patients being particularly under-served.



- **Best-practice health services**—one of the core objectives of the MBS 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 the Medical Services Advisory Committee (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.
- **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.
- **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.

2.4 The Taskforce’s approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce’s brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The Taskforce also established PCRGs to review MBS items largely provided by non-doctor health professionals. The clinical committees and PCRGs are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

2.4.1 What is a primary care reference group?

The Taskforce established the PCRGs to focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care. The MBS Review Taskforce established five PCRGs:



- Aboriginal and Torres Strait Islander Health Reference Group
- Allied Health Reference Group
- Mental Health Reference Group
- Nurse Practitioner Reference Group, and
- Participating Midwives Reference Group.

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 General Practice and Primary Care Clinical Committee (GPPCCC). Each PCRG makes 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.

2.4.2 The 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.



3 About the Aboriginal and Torres Strait Islander Health Reference Group

The Aboriginal and Torres Strait Islander Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items within its area of responsibility, as well as longer-term topics, and to respond to referred questions from the GPPCCC.

3.1 Aboriginal and Torres Strait Islander Health Reference Group members

The Reference Group consists of 12 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Aboriginal and Torres Strait Islander Reference Group members

Name	Position/organisation	Declared conflict of interest
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



Name	Position/organisation	Declared conflict of interest
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
Dr Lucas de Toca (Departmental advisor)	Principal Advisor, Office of Health Protection, Australian Department of Health	Nil

3.2 Conflicts of interest

All members of the Taskforce, clinical committees and PCRGs are asked to declare any conflicts of interest at the start of their involvement and are reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1.

It is noted that many Reference Group members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Reference Group and the Taskforce, it was agreed that this should not prevent members from participating in the review.

3.3 Areas of responsibility of the Reference Group

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 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 (the full list of items can be found in Appendix A):

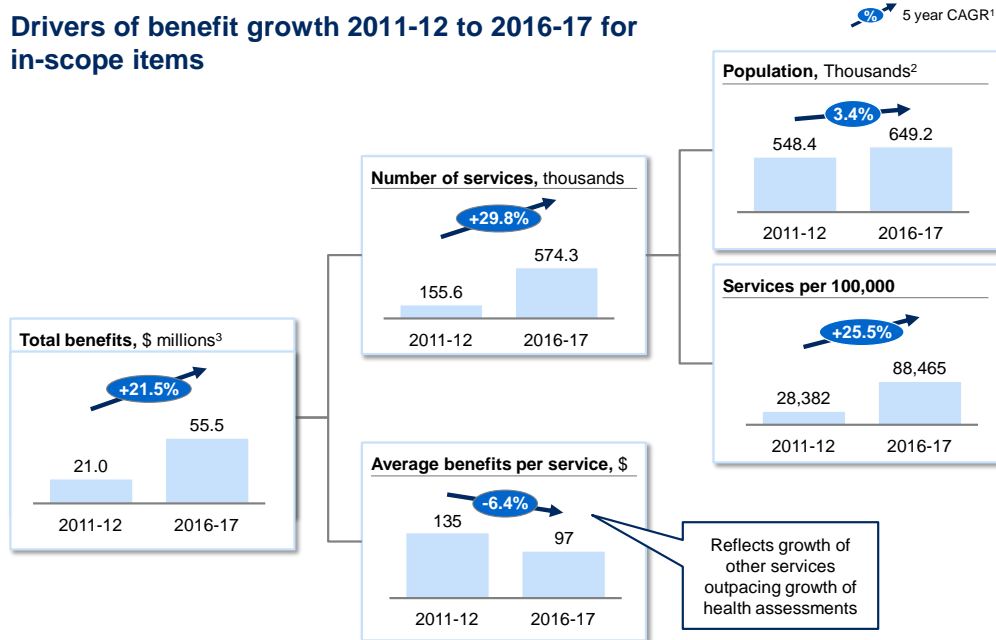
- A14, health assessments, subgroup 2 – Aboriginal and Torres Strait Islander peoples' health assessment (item 715).
- M3, allied health services (item 10950).



- M11, allied health services for Aboriginal and Torres Strait Islander peoples who have had a health assessment (items 81300–81360).
- M12, services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a 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 1).

Figure 1: Drivers of benefit growth, 2011-12 to 2016-17, for in-scope items



¹ Compound Annual Growth Rate

² Population of Aboriginal and Torres Strait Islanders (Australian Bureau of Statistics)

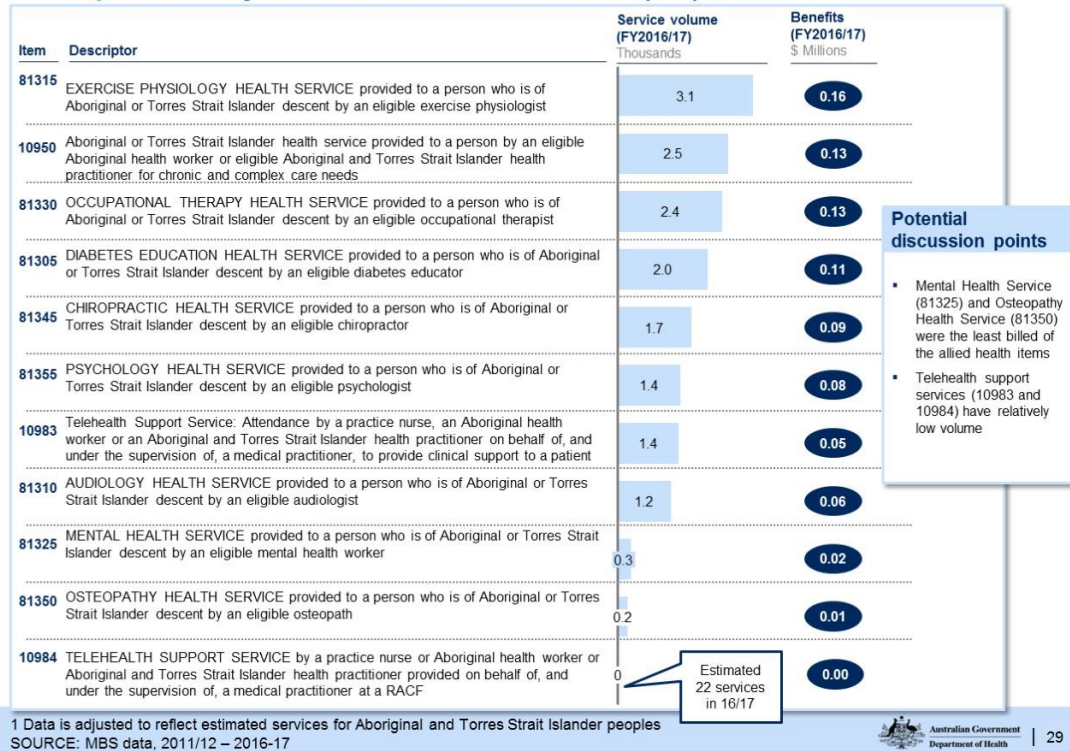
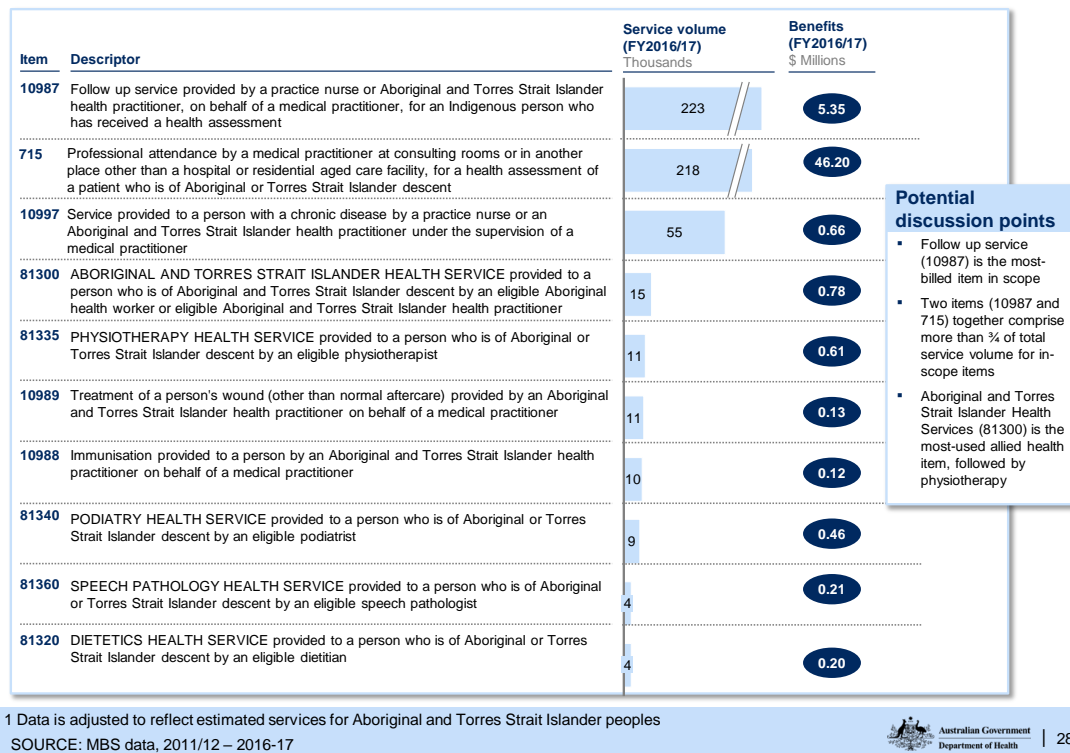
³ Data is adjusted to reflect estimated services for Aboriginal and Torres Strait Islander peoples

SOURCE: MBS data, 2011/12 – 2016-17,

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 2). In 2016-17, mental health services and osteopathy health services were the least billed allied health items (Figure 2).



Figure 2: In-Scope items by service volume, 2016-17

In-scope items by service volume in 2016-17 (2/2)¹In-scope items by service volume in 2016-17 (1/2)¹



3.4 Summary of the 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:

- 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 journals and other sources, such as professional societies.

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



4 Main themes

The Aboriginal and Torres Strait Islander population is becoming increasingly urbanised. Since the 1996 Census, the proportion of Aboriginal and Torres Strait Islander people living in urban areas has increased from 73 per cent to 79 per cent. This was largely driven by the proportion of the Aboriginal and Torres Strait Islander population in capital cities, which has increased from 30 per cent in 1996 to 35 per cent in 2016 (1).

The overall pattern of disease burden among Aboriginal and Torres Strait Islander peoples broadly followed population size, though with the total burden in inner regional areas being somewhat lower than might be expected based on population. Remote and very remote areas accounted for a higher proportion of disease burden (11 per cent and 16 per cent, respectively) than population (8 per cent and 14 per cent, respectively) (2).

It is important to consider these factors when determining how the recommendations of this report could impact access differently in rural/remote and urban communities.

4.1 Models of primary care financing and funding

Several Reference Group discussions focused on the appropriate funding model for primary care service delivery for Aboriginal and Torres Strait Islander peoples (as well as for all Australians in rural and remote areas). There were two recurring themes in these discussions: managing patients' ability to cover out-of-pocket costs, and the small health care workforce in some areas and communities. The Reference Group noted that structural barriers in the MBS funding model limited its ability to address these challenges.

The Reference Group also discussed the possibility of an MBS item loading factor (the exact loading factor would require some research) for Aboriginal and Torres Strait Islander professionals delivering care (this includes doctors, nurses, health workers and practitioners and allied health workers). These professionals would receive a loading factor for each MBS item claimed (3) (4). This loading factor would serve two purposes:

- Remunerate Aboriginal and Torres Strait Islander health professionals for their cultural capability (provision of culturally appropriate care whilst also guiding non-Aboriginal and Torres Strait Islander health professionals in the provision of culturally appropriate care), and



- Provide incentives for training and employment of Aboriginal and Torres Strait Islander health professionals within the broader health system.

4.1.1 Existing initiatives to improve access and outcomes in primary care

Most primary health care in Australia is publicly financed but privately delivered. A range of models are used across the country, and a number of policy initiatives have attempted to facilitate change in the approach to primary care, with the goal of improving access and outcomes by varying the financial and/or service delivery approach. Examples of these approaches include:

- Inter-professional primary health care teams and team-based care arrangements, including care coordination
- Patient enrolment with a primary care provider, and
- Financial incentives and blended payment schemes.

These changes have mostly been incremental and are based on evidence from Canada and the United Kingdom, where evaluations have identified a range of improvements to access and treatment outcomes associated with varying or blended models of primary care (5).

4.1.2 The role of grant funding

The Reference Group recognised the continued importance of grant funding, particularly for Aboriginal Community Controlled Health Organisations (ACCHOs), given the disparity in access to MBS items between Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples.

4.2 Prevention versus chronic disease management

The Reference Group spent considerable time discussing the Aboriginal and Torres Strait Islander peoples' health assessment (item 715), particularly the content of the assessment tool. It also discussed the importance of this tool for 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.

There is a perceived tension in the MBS between the prevention and treatment of disease, and this is linked to broader questions about what the MBS can and should be used for. This tension persists, despite changes in 2010 to the item descriptors for Level B, C and D allowing GP consultations to include "providing appropriate preventive health care" (6).

There is also a range of MBS items that aim to identify risks for disease, including the health assessment item for Aboriginal and Torres Strait Islander peoples. These changes were made to support patient access to preventive-based clinical activities, and GPs are eligible to claim Medicare Schedule fees for attendances when preventive health care has been provided.



While a great deal of discussion still tends to focus on the need to treat the presenting issue, there may be opportunities to provide preventive interventions as well. The Aboriginal and Torres Strait Islander peoples' health assessment (item 715) provides a rare opportunity to encourage and support preventive activities.

4.3 MBS data on Aboriginal and Torres Strait Islander peoples

This review has provided an opportunity to examine MBS data concerning Aboriginal and Torres Strait Islander peoples, using the Voluntary Indigenous Identifier (VII). It is estimated that around 70 per cent of the Aboriginal and Torres Strait Islander population are recorded in the Medicare database (as of 30 June 2018). Other than the Census, this is the largest database of Aboriginal and Torres Strait Islander peoples. Opportunities to use this data have been limited, but it has the potential to enable assessments of MBS item uptake and other health outcomes in order to improve services. The VII is intended for this purpose, and the Reference Group welcomes the ongoing work to broaden and increase the use of this data for policy and research with appropriate Indigenous data governance.

4.4 Updating and realigning MBS item descriptors

The Reference Group discussed updating item descriptors within existing MBS items. This included bringing item descriptors in line with contemporary naming conventions—for example, replacing the term “practice nurse” with “nurse” across the MBS.



5 Recommendations

A list of the in-scope items considered by the Reference Group can be found in Appendix A.

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.

5.1 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.

5.1.1 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:

- (i) the service is provided to a Aboriginal and Torres Strait Islander person; and
- (ii) the person is not an admitted patient of a hospital; and
- (iii) the service is bulk-billed in respect of the fees for:
 - this item, and
 - the other item in this table applying to the service.

5.1.2 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.

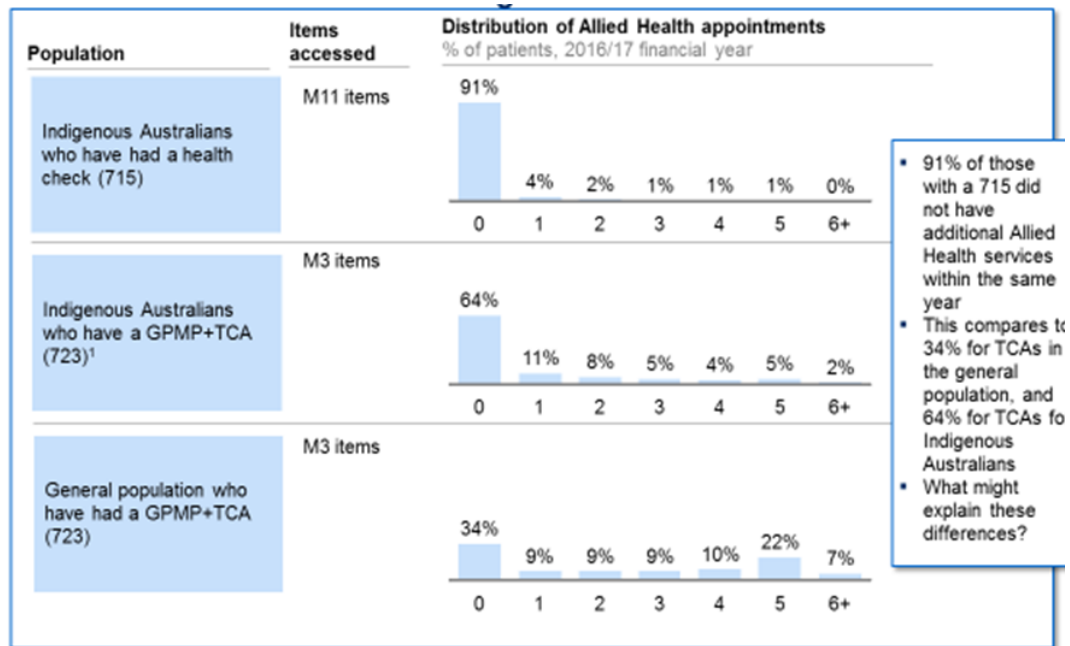


- Despite some improvement in the number of Aboriginal and Torres Strait Islander peoples accessing health assessments and follow-up appointments over the last several years, uptake of these services remains low (30 per cent) compared to the size of the Aboriginal and Torres Strait Islander population (7).
- 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 3). 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⁽¹⁾.
- 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. (8)

¹ . 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 3: Average use of allied health appointments after referral from GPMPs and health assessments for Aboriginal and Torres Strait Islander peoples



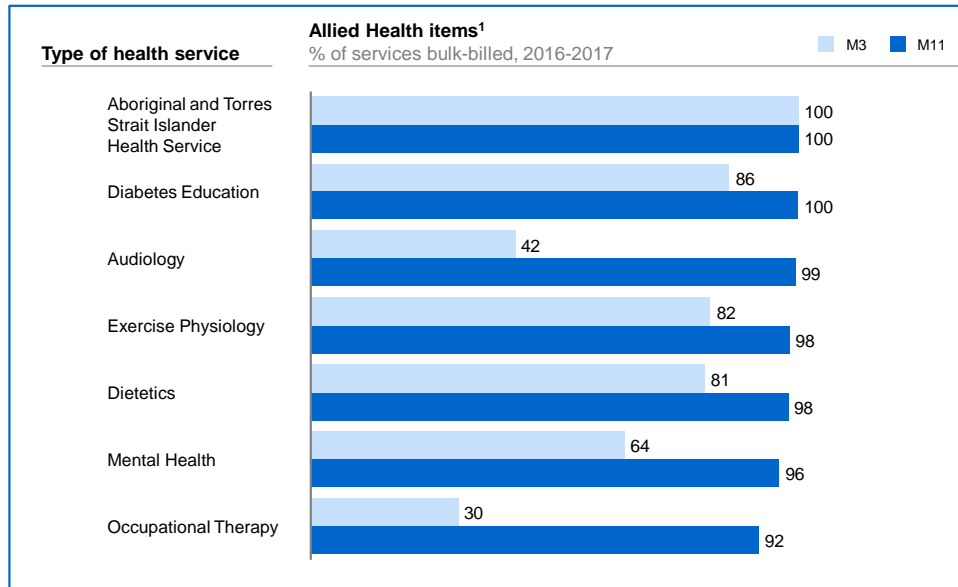
- Out-of-pocket fees may be higher than current MBS data indicates. While official measures of bulk-billing rates for items 81300–81360 and 10950 are high (ranging between 26 per cent and 100 per cent for items 81300–81360, and 100 per cent for item 10950; Figure 4 and Figure 5), the Reference Group 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 4: Bulk-billing rates for M3 and M11 items

IN-SCOPE ITEMS

C Bulk-billing rates by item number, M3 and M11 (1/2)



¹ Excludes atypical provider claims (e.g., chiropractor claiming for osteopathy), unless there were >100 services of this type in the year

SOURCE: MBS data, 2016-17

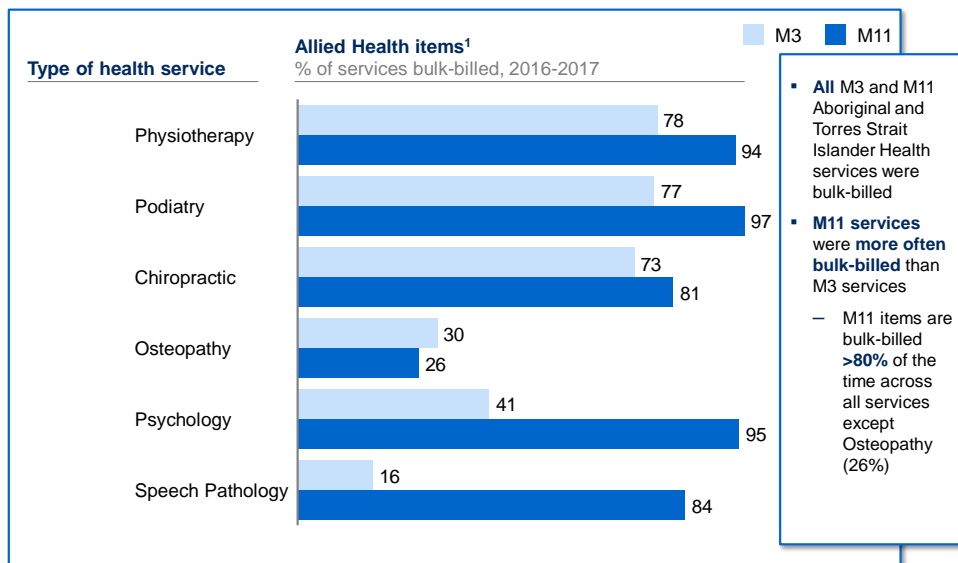
Australian Government
Department of Health

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Figure 5: Bulk-billing rates for M3 and M11 items

IN-SCOPE ITEMS

C Bulk-billing rates by item number, M3 and M11 (2/2)



¹ Excludes atypical provider claims (e.g., chiropractor claiming for osteopathy), unless there were >100 services of this type in the year

SOURCE: MBS data, 2016-17

Australian Government
Department of Health

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- 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 (9).
- Chronic diseases—such as cardiovascular disease (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 (10). 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) (11).
- 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 4 and Figure 5). The average bulk-billing rate for allied health services for those who have a chronic care management plan (M3 items) is 62 per cent.
- Research has identified the removal of cost barriers as a potential avenue for improving follow-up care (12).
- 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.

5.1.3 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:

- (i) There should be two to 10 participants per group
- (ii) Items should be created for each eligible M11 provider



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

5.1.4 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, New South Wales, 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 (13). 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 New South Wales, South Australia and Queensland (14). 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 (15).

- 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.

5.1.5 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*”.

5.1.6 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.
 - 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.

5.1.7 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).



5.1.8 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 Allied Health Reference Group'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 3).
- 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.



5.1.9 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).

5.1.10 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 (APA), 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 to 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 dietitian, psychologist, podiatrist and/or diabetes nurse.
- Although few Aboriginal and Torres Strait Islander peoples reach the cap of five sessions under item 715 (Figure 3), 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 Department of Veterans' Affairs 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 (16).



- 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.

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

5.2.1 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

5.2.2 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 (17).
- 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.

5.3 Aboriginal and Torres Strait Islander peoples' health assessments

5.3.1 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 the Department of Health'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 the Department, or a



template that contains all the components of the form issued by the Department, with the proposed item descriptor as follows:

Item 715 – example item descriptor

Professional attendance by a general practitioner 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:

- support initial and ongoing engagement in comprehensive primary healthcare in a culturally safe way
- provide evidence-based age-appropriate health information and services to support health and wellbeing for primary and secondary disease prevention
- identify and support management of health and health-related needs
- 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)
- 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

continued on next page



Associated Note Item 715 – example descriptor *continued*

- 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.
- general practitioner-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
- 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:

- provide consent for the health assessment;
- share the child's relevant health history and living circumstances; and
- share knowledge and responsibility for health needs identified and planned follow-up

Note: The Reference Group is aware that the Royal Australian College of General Practitioners (RACGP) and the National Aboriginal Community Controlled Health Organisation (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.

5.3.2 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 (18).
- 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 (19). 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 (20).
 - 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 (18).
- 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.

5.3.3 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)” (Appendix F);
- 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.

5.3.4 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 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 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) (14).
- 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.

5.4 Services provided on behalf of a medical practitioner

5.4.1 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
- 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 consultations after the health assessment

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

and

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

and

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.

and

**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
- (b) the person is not an admitted patient of a hospital; and
- (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and
- (d) 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

5.4.2 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 (21). Aboriginal and Torres Strait Islander health workers were also recognised as important in providing cultural safety and support, and helping to alleviate concerns (21). Face-to-face discussions are the preferred source of information for Aboriginal and Torres Strait Islander peoples (21).
- 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 (22) and 1,256 Aboriginal and Torres Strait Islander health workers in Australia (2011 figures) (11).



- 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 administering medications for Aboriginal and Torres Strait Islander health workers and health practitioners (23).
- In New South Wales, 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 (23).
- 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 (11).
- Increasing patients' access to services from Aboriginal and Torres Strait Islander health workers will improve the quality of care in rural and remote areas.

5.4.3 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, and
- 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

and

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.

5.4.4 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.



6 Longer-term recommendations

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

6.1.1 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.

6.1.2 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.



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

6.2.1 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.



6.2.2 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 (11). This is partly because Aboriginal and Torres Strait Islander peoples are significantly under-represented in the Australian health workforce (11).
- Aboriginal and Torres Strait Islander peoples living in rural and remote communities suffer poor outcomes partly because of their educational disadvantage and their remoteness (24).
- 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 (25).
- 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 (26). 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 people 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.

6.2.3 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:

- (i) Target primary health care bodies operating in areas with substantial concentrations of Aboriginal and Torres Strait Islander peoples.
- (ii) Involve peak bodies in the Aboriginal and Torres Strait Islander workforce, such as the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA).
- (iii) Use online resources to define the scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners.
- (iv) Articulate the health benefits of involving Aboriginal and Torres Strait Islander health workers and health practitioners in primary health care.
- (v) Detail specific steps that primary care practices can take to integrate Aboriginal and Torres Strait Islander health workers.
- (vi) Include details of any workforce incentives for practices hiring Aboriginal and Torres Strait Islander health workers and health practitioners, as specified in Recommendation 9.
- (vii) Work towards a national scope of practice [aligned with Item 715 Aboriginal and Torres Strait Islander peoples' health assessment] for Aboriginal and Torres Strait Islander health workers and health practitioners.

6.2.4 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 (27).
- 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; see Section 5.3.3) would help to increase awareness of their role and scope of practice.

6.3 Data infrastructure

6.3.1 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:

- a. 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:
 - (i) 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.
 - (ii) Link MBS VII data with other administrative/routinely collected data where appropriate.
 - (iii) Ensure appropriate analysis and reporting is undertaken over time.
 - (iv) Ensure that evidence for improving uptake is incorporated into any policy decision-making process and is provided by people with relevant expertise.



- (v) 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.

and

- b. that where appropriate these changes should be mirrored in the PBS.

6.3.2 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 (28) (29) (30). 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) (31). Use of item 715 (and its predecessor items) has increased over time, but growth in health checks has flattened in recent years (31).
- 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 (32).
- These improvements should be aligned with the 2006 Australian Health Ministers' Advisory Council National Aboriginal and Torres Strait Islander Health Data Principles.

6.4 Revenue generated by the 19(2) Directions for state and territory clinics

6.4.1 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 the Department of Health, detailing total Aboriginal and Torres Strait Islander primary health care grant expenditure and MBS income and expenditure.

6.4.2 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) (33).

- 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 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 people.
- 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.

6.5 Social and emotional well-being support for Aboriginal and Torres Strait Islander peoples

6.5.1 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:

- (i) Community health and mental health workers (sometimes referred to as social and emotional well-being workers)
- (ii) Care coordinators, and
- (iii) Traditional and spiritual healers e.g. Ngangkari.

6.5.2 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 (34).
- 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 (35).
- 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 (36).
- 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 (36). 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 (37).
- 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 (36).



6.6 Culturally safe health services

6.6.1 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.

6.6.2 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 (38).
- 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 (39).
- 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 people. Racism, in all its forms, affects Aboriginal people by increasing blood pressure leading to long term cardiovascular disease damage, creating anxiety and depression (40).
- 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 (41) 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 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 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 (42).



7 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.



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9 Glossary

Term	Description
ACCHO	Aboriginal Community Controlled Health Organisations are controlled by, and accountable to, Aboriginal and Torres Strait Islander people in the areas in which they operate. ACCHOs aim to deliver holistic, comprehensive and culturally appropriate health care to the communities that control them.
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period
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).
CVD	Cardiovascular disease
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
FTE	Full-time equivalent
GP	General practitioner
GPMP	GP Management Plan
GPPCCC	General Practice and Primary Care Clinical Committee
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



Term	Description
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 on 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	Medicare Benefits Schedule
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
Minister, The	Minister for Health
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.
MSAC	Medical Services Advisory Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
New service	Describes when a new service has been recommended, 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.
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
PBS	Pharmaceutical Benefits Scheme
PCRG	Primary care reference group
RACGP	Royal Australian College of General Practitioners



Term	Description
Reference Group, The	The Aboriginal and Torres Strait Islander Health Reference Group of the MBS Review
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).
TCA	Team care arrangements
Taskforce, The	MBS Review Taskforce
Total benefits	Total benefits paid in 2014-15 unless otherwise specified
VII	Voluntary Indigenous Identifier



Appendix A Full list of 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%



Item	Descriptor	Schedule fee	Services 2016-17	Benefits 2016-17	Services 5-year annual avg. growth
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 Full list of recommendations

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:

- (i) the service is provided to a Aboriginal and Torres Strait Islander person; and
- (ii) the person is not an admitted patient of a hospital; and
- (iii) the service is bulk-billed in respect of the fees for:
 - this item, and
 - the other item in this table applying to the service.

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:

- (i) There should be two to 10 participants per group
- (ii) Items should be created for each eligible M11 provider
- (iii) 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
- (iv) The sessions should be accessible through items 715 and 723 (refer to Recommendation 6).

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”*.

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).

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).

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; - 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

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.
 - (ii) 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 the Department of Health’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 the Department, or a template that contains all the components of the form issued by the Department, with the proposed item descriptor as follows:

Item 715 – example item descriptor

Professional attendance by a general practitioner 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:

- g) recognition of patient health priorities; and
- h) collection of relevant information, including a comprehensive patient history; and
- i) relevant physical examination; and
- j) initiating interventions, investigations and referrals; and
- k) providing comprehensive preventive health care advice and other measures informed by overall assessment and patient priorities; and
- l) 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:

- support initial and ongoing engagement in comprehensive primary healthcare in a culturally safe way
- provide evidence-based age-appropriate health information and services to support health and wellbeing for primary and secondary disease prevention
- identify and support management of health and health-related needs
- 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)
- 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

continued on next page

**Associated Note Item 715 – example descriptor *continued***

- 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 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
- general practitioner-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
- 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:

- provide consent for the health assessment;
- share the child's relevant health history and living circumstances; and
- share knowledge and responsibility for health needs identified and planned follow-up

Note: The Reference Group is aware that the Royal Australian College of General Practitioners (RACGP) and the National Aboriginal Community Controlled Health Organisation (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.



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)” (Appendix F);
- 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.

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
- 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;

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

and

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

and

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.



and

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
- (b) the person is not an admitted patient of a hospital; and
- (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and
- (d) 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

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, and
- 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



and

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.

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.

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 and 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.

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:

- (i) Target primary health care bodies operating in areas with substantial concentrations of Aboriginal and Torres Strait Islander peoples.
- (ii) Involve peak bodies in the Aboriginal and Torres Strait Islander workforce, such as the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA).
- (iii) Use online resources to define the scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners.



- (iv) Articulate the health benefits of involving Aboriginal and Torres Strait Islander health workers and health practitioners in primary health care.
- (v) Detail specific steps that primary care practices can take to integrate Aboriginal and Torres Strait Islander health workers.
- (vi) Include details of any workforce incentives for practices hiring Aboriginal and Torres Strait Islander health workers and health practitioners, as specified in Recommendation 9.
- (vii) Work towards a national scope of practice [aligned with Item 715 Aboriginal and Torres Strait Islander peoples' health assessment] for Aboriginal and Torres Strait Islander health workers and health practitioners.

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:

- a. 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:
 - (i) 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.
 - (ii) Link MBS VII data with other administrative/routinely collected data where appropriate.
 - (iii) Ensure appropriate analysis and reporting is undertaken over time.
 - (iv) Ensure that evidence for improving uptake is incorporated into any policy decision-making process and is provided by people with relevant expertise.
 - (v) 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.
- and
- b. that where appropriate these changes should be mirrored in the PBS.

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 the Department of Health, detailing total Aboriginal and Torres Strait Islander primary health care grant expenditure and MBS income and expenditure.

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:

- (i) Community health and mental health workers (sometimes referred to as social and emotional well-being workers)
- (ii) Care coordinators, and
- (iii) Traditional and spiritual healers e.g. Ngangkari.

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.



Appendix C Summary for consumers

This table describes the medical service, the recommendation(s) of the clinical experts and why the recommendation(s) has been made.

Recommendation 1: Enable bulk-billing incentives to be billed in conjunction with provision of allied health services for Aboriginal and Torres Strait Islander peoples.

Item	What it does	Committee recommendation	What would be different	Why
New items 10990A 10991A 10992A	Bulk-billing incentives for allied health appointments	Enable bulk-billing incentives (mirroring 10990, 10991 and 10992) to the provision of allied health services.	This recommendation would allow bulk-billing incentives to be claimed with allied health items, including if they have been referred by a doctor.	Currently, allied health service use by Aboriginal and Torres Strait Islander peoples is relatively low. Increasing bulk-billing incentives will encourage more allied health practitioners to refer and provide preventative and chronic disease management services for Aboriginal and Torres Strait Islander peoples which will reduce hospitalisation rates and improve long-term health outcomes.

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

Item	What it does	Committee recommendation	What would be different	Why
81300-81360	Provides allied health services for Aboriginal and Torres Strait Islander peoples	Enable all allied health services available to Aboriginal and Torres Strait Islander peoples to be provided as group therapy	There would be a suite of new items that allow all allied health services for Aboriginal and Torres Strait Islander peoples to be provided as group therapy, and patients and practitioners can choose which is more appropriate	This recommendation focuses on increasing the use of allied health services by providing options for group services. Group services may offer increased cultural safety and appropriateness for Aboriginal and Torres Strait Islander patients, and could encourage more Aboriginal and Torres Strait Islander patients to engage in allied health therapy where there is a social and community aspect.



Recommendation 3: Change the name of M11 and M3 items to “Comprehensive primary health care follow up services”.

Item	What it does	Committee recommendation	What would be different	Why
81300-81360 and 10950-10970	Provide allied health services for Aboriginal and Torres Strait Islander peoples	Change the name of M11 and M3 items to “Comprehensive primary health care follow-up services”.	Aboriginal and Torres Strait Islander health workers, Aboriginal and Torres Strait Islander health practitioners, mental health nurses and nurses would be more accurately included as practitioners who can deliver care, rather than just allied health professionals.	Changing the name of allied health items would more accurately reflect the group of professionals that can offer the range of services to Aboriginal and Torres Strait Islander patients.

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.

Item	What it does	Committee recommendation	What would be different	Why
81300-81360 and 10950-10970	Provide allied health services for Aboriginal and Torres Strait Islander peoples	Pool access to allied health items that are available following a health assessment and the creation of a GPMP/TCA.	Aboriginal and Torres Strait Islander patients who have had an Aboriginal and Torres Strait Islander peoples’ health assessment and a TCA would be able to pool their allied health services for a total of 10 services through a single referral form, and would not have to go through an additional chronic management plan health assessment to unlock the additional 5 services.	This recommendation focuses on decreasing barriers to accessing allied health services for Aboriginal and Torres Strait Islander peoples. Currently, Aboriginal and Torres Strait Islander patients who have had an Aboriginal and Torres Strait Islander peoples’ health assessment and a TCA need to claim each set of allied health services separately and through additional assessments; by reducing this administrative burden and allowing pooling, Aboriginal and Torres Strait Islander patients can have access to necessary allied health care as they need it.


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

Item	What it does	Committee recommendation	What would be different	Why
81300-81360	Provide allied health services for Aboriginal and Torres Strait Islander peoples	Increase the number of allied health sessions available for Aboriginal and Torres Strait Islander peoples to 10 per year.	Patients who have been referred to allied health services after a health assessment would have access to 10, rather than 5 allied health services.	Other recommendations that allow pooling of services and new group therapy services are likely to increase the use of allied health services to over 5 per year.

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

Item	What it does	Committee recommendation	What would be different	Why
New item	Allows for group follow up after health assessment	Create a new item for group service delivery of comprehensive follow-up services after a health assessment.	Aboriginal and Torres Strait Islander patients would be able to receive follow up care in small groups of 2-10 participants, where the service is relevant	This recommendation focuses on increasing the availability and use of group services. Group services may offer increased cultural safety for Aboriginal and Torres Strait Islander patients, and increase the likelihood of patients attending follow-up services.


Recommendation 7: Ensure that health assessment templates and content (Item 715) reflect best practice.

Item	What it does	Committee recommendation	What would be different	Why
Aboriginal and Torres Strait Islander peoples' health assessment items	Health assessment templates are used to guide clinicians when assessing Aboriginal and Torres Strait Islander patients, such as heart disease risk calculators and alcohol use calculators.	Update the <i>National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander People</i> to ensure that it aligns with current practice and evidence and becomes a "living guideline", and ensuring that a patient's regular doctor completes their health assessment where possible.	All Aboriginal and Torres Strait Islander patient assessment templates would be updated to be consistent with national guidelines and standardised by the Department of Health to make them easy to use. Health assessment would be done by a patient's usual doctor or usual medical practice.	This recommendation focuses on improving the quality of health assessments so that patients have treatment plans that best reflect their needs. Standardisation would ensure that patients would receive culturally appropriate, consistent care with less chance for missing important assessments.

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

Item	What it does	Committee recommendation	What would be different	Why
715	Aboriginal and Torres Strait Islander peoples' health assessments	Update the allied health referral form for item 715 to ensure that patients can access the allied health professional that is most appropriate for them, and encourage electronic forms as the main method	The allied health referral form would be updated so that naming a specific allied health professional at their role to whom the patient is being referred is not a mandatory field. The use of electronic forms would be encouraged. The need for a separate referral form and reporting outside of the clinical record would be removed where there is a shared electronic health record used by the GP and allied health professional.	This recommendation focuses on ensuring clear communication between the patient and their doctor to facilitate access to allied health services. The updated form would ensure patients are more aware of their choices of allied health services, and encouraging electronic forms will reduce issues with misplacement of forms.



Recommendation 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).

Item	What it does	Committee recommendation	What would be different	Why
10987, 10988, 10989, 10997	Aboriginal and Torres Strait health practitioner items.	Allow qualified Aboriginal and Torres Strait Islander health workers access to items provided on behalf of a medical practitioner by Aboriginal and Torres Strait Islander practitioners, where these items fall within their scope of practice.	Qualified Aboriginal and Torres Strait Islander health workers will be able to provide MBS services such as follow up of health assessments, immunisations, treatment of wounds and chronic disease management, where they are doing so on the instruction of a doctor and within their scope of practice.	This recommendation focuses on improving the availability of services for Aboriginal and Torres Strait Islander peoples. Qualified and trained Aboriginal and Torres Strait health workers play an important role in providing high quality health care to Aboriginal and Torres Strait Islander peoples, especially in areas where there is an insufficient supply of health practitioners.

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 (10988 and 10989).

Item	What it does	Committee recommendation	What would be different	Why
10988, 10989	Immunisations (10988) and wound treatment (10989) provided by an Aboriginal and Torres Strait Islander health practitioners	Enable patients to access rebates for all follow-up services when provided by a nurse on behalf of a medical practitioner in Aboriginal and Torres Strait Islander primary health care.	Nurses working in aboriginal primary care health services will be able to provide MBS services such as immunisations and treatment of wounds, where they are doing so on the instruction of a doctor and within their scope of practice.	This recommendation focuses on improving the availability of services for Aboriginal and Torres Strait Islander peoples. Nurses play an important role in providing high quality health care to Aboriginal and Torres Strait Islander peoples, especially in areas where there is an insufficient supply of health practitioners.


Recommendation 11: Conduct research to enable MBS service provision by non-registered Aboriginal and Torres Strait Islander health professionals.

Item	What it does	Committee recommendation	What would be different	Why
Nil	N/A	Conduct research to enable MBS service provision by non-registered Aboriginal and Torres Strait Islander health professionals, such as Ngangkari healers and other Aboriginal and Torres Strait Islander health professionals who do not have formal registration bodies.	This research would provide the basis to support Aboriginal and Torres Strait Islander health professionals such as Ngangkari healers to participate in providing select and appropriate MBS services.	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.

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

Item	What it does	Committee recommendation	What would be different	Why
Nil	N/A	Invest in the growth and sustainability of the Aboriginal and Torres Strait Islander health worker and health practitioner workforce.	Investments in the growth of the Aboriginal and Torres Strait Islander health worker and health practitioner workforce would ensure more educational pathways to becoming qualified, would facilitate building the health workforce in areas of shortage, and would provide more structured career paths.	There is a shortage of qualified health professionals who can provide culturally and clinically appropriate care to Aboriginal and Torres Strait Islander peoples, and supporting the growth of the Aboriginal and Torres Strait Islander health worker and health practitioner workforce would be an efficient and effective way to increase access to high quality and culturally appropriate care.



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.

Item	What it does	Committee recommendation	What would be different	Why
Nil	N/A	Invest in an awareness campaign that explains the roles and scopes of practice of Aboriginal and Torres Strait Islander health workers and health practitioners.	A targeted, nation-wide awareness campaign would improve the Aboriginal and Torres Strait Islander community's awareness of available services through health workers and health practitioners.	There is a lack of understanding around what services and benefits Aboriginal and Torres Strait Islander health workers and health practitioners can provide. This results in work positions that don't best utilise their skills, knowledge and experience. An awareness campaign would improve the employment of Aboriginal and Torres Strait Islander health workers and practitioners.

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.

Item	What it does	Committee recommendation	What would be different	Why
Nil	N/A	Establish a group that can collect and analyse MBS data to best advise on how to improve Aboriginal and Torres Strait Islander peoples' MBS items.	Developing a special group to manage Aboriginal and Torres Strait Islander peoples' MBS data would ensure that this data is used, made available and reported to improve Aboriginal and Torres Strait Islander health policy decisions.	This recommendation focuses on ensuring that practices and policies affecting Aboriginal and Torres Strait Islander peoples is informed by reliable, transparent and high quality data, which currently does not occur.



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.

Item	What it does	Committee recommendation	What would be different	Why
Nil	N/A	Invest all MBS revenue generated from the 19(2) Directions for Aboriginal and Torres Strait Islander peoples in state and territory clinics back into primary health care services.	Primary health clinics serving Aboriginal and Torres Strait Islander peoples would receive any MBS funds that their salaried doctors earned back, specifically for investing further into Aboriginal and Torres Strait Islander health services.	It is important to ensure that the additional MBS revenue generated through the 19(2) Direction leads to additional primary health care services for Aboriginal and Torres Strait Islander peoples as was originally intended. It is claimed that this practice has been reduced over the last decade, and has resulted in a loss of potential Aboriginal and Torres Strait Islander health primary care services.

Recommendation 16: Enhance social and emotional well-being support for Aboriginal and Torres Strait Islander peoples.

Item	What it does	Committee recommendation	What would be different	Why
New Item	Provides social and emotional wellbeing through a holistic network of relationships between individuals, family, kin and community.	Enhance social and emotional well-being support for Aboriginal and Torres Strait Islander peoples.	Patients would be able to access an MBS rebate when attending social and emotional wellbeing services.	Social and emotional wellbeing provides a foundation for effective physical and mental health promotion strategies

**Recommendation 17: Promote culturally safe health services for Aboriginal and Torres Strait Islander peoples to all health providers.**

Item	What it does	Committee recommendation	What would be different	Why
Nil	Intends to improve cultural safety for Aboriginal and Torres Strait Islander peoples through increased awareness and/or training of all health providers.	Promote cultural safety for all health providers.	Increased access to the health services by Aboriginal and Torres Strait Islander peoples through the reduction of racially discriminatory practices.	Culturally safe and appropriate services can improve equality and reduced disparity of health outcomes.



Appendix D Response to the Renal Medicine Clinical Committee

This appendix describes the Reference Group response to the Renal Medicine Clinical Committee.

Referral Source	Topic	Reference Group Response
Renal Medicine Clinical Committee Report	Review health assessment items 701, 703, 705, 707 and 715 in relation to both eligibility and content.	The Reference Group considers items 701-707 outside their scope; 715s are being reviewed by the group.
	Incorporate an integrated health assessment MBS item for vascular disease, diabetes and kidney disease, with eligibility and content that reflect evidence-based guidelines such as those contained in the Royal Australian College of General Practitioners' (RACGP) Guidelines for Preventive Activities in General Practice.	The Reference Group notes that these concerns will be reflected in the work on item 715 being undertaken by the group and coordinated with Royal Australian College of General Practitioners' and National Aboriginal Community Controlled Health Organisation.



Appendix E Response to the GPPCCC referred questions

This appendix describes the Reference Group response to GPPCCC on 5 July 2018

Figure 6: Rebate attendance at case conferences by non-doctor health professionals

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH REFERENCE GROUP

Rebate attendance at case conferences by non-doctor health professionals

Question	Draft response	Rationale and evidence
To what extent do Aboriginal Health Workers and Practitioners currently attend case conferences? What are the main barriers to attendance?	<p>AHWs and AHPs should be at more case conferences.</p> <p>The role itself can be a barrier to attendance, due to the lack of awareness of the benefits of involving AHWs or AHPs. The scope of practice of AHWs and AHPs is quite disparate and this can also contribute to lack of awareness or confusion.</p> <p>GPs and other health professionals require better education about the role of an AHP/AHW.</p> <p>Remuneration for service is also a major barrier to case conference participation. Specific items for AHW attendance at case conferences should be introduced to incentivise AHW/AHP participation and thus facilitate access for Aboriginal and Torres Strait Islander patients.</p> <p>The inadequate attendance at case conferences is compounded by under resourced AHW and AHP workforce training and certification.</p>	<ul style="list-style-type: none"> Lack of data on attendance is itself an argument for an item number, as without this there is no way to formally track attendance at case conferences Pending approval to share draft report with relevant evidence
What does the evidence say about the benefit of their attendance at case conferences?	<p>The benefit of AHW/AHP attendance is twofold: the primary healthcare expertise as well as having the cultural safety that comes with having an Aboriginal or Torres Strait Islander person present. (Although the Reference Group acknowledges that other Aboriginal healthcare professionals may also be involved in the patient's care (e.g., a GP or an RN))</p> <p>There are benefits in smoothing the discharge process as well: ensuring transition from hospital care to appropriate chronic care in Aboriginal and Torres Strait Islander populations.</p>	<ul style="list-style-type: none"> For evidence, see: Expanding roles of Aboriginal health workers in the primary care setting: Seeking recognition by Penny Abbott, Elaine Gordon & Joyce Davison pp 157-164 Received 22 Nov 2006, Accepted 31 May 2007, Published online: 17 Dec 2014

Figure 7: Including care facilitation services from a registered nurse or Aboriginal and Torres Strait Islander health worker in GPMP allied health appointments

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH REFERENCE GROUP

Include care facilitation services from a registered nurse or Aboriginal health worker in GPMP allied health appointments

Question	Draft response	Rationale and evidence
Is there sufficient access to care facilitation services from Aboriginal Health Workers and Health Practitioners currently?	<p>There is currently insufficient access to care facilitation from AHWs/AHPs, despite significant need.</p> <p>Remuneration of AHW facilitators is a clear access barrier. Care facilitation services would probably be best funded outside of a FFS model. Yet given the scope of the MBS review a separate item for AHW/AHP care facilitation is recommended.</p> <p>Workforce limitation is another driver of low levels of care facilitation. Training and accreditation is expensive underfunded. More generally, primary care coordination is underfunded.</p>	<ul style="list-style-type: none"> ...
Is the benefit of care facilitation services from an Aboriginal Health Worker or Practitioner equal to or greater than the benefit of an allied health appointment?	<p>There is significant benefit to care facilitation services from an AHW/AHP. The role is different to that of other AH practitioners in that AHWs/AHPs facilitate cultural safety for Aboriginal and Torres Strait Islander peoples accessing care.</p> <p>However, there is currently an issue where GPs are reluctant to refer to the existing AHW item under allied health, because other allied health services will take precedence. This is compounded by the potential of limited numbers of allied health items available. A recommendation to include AHW care facilitation services as part of a GPMP/HA would be unlikely to resolve this issue. While care facilitation should be encouraged, adding a care facilitation item under allied health is not necessarily the right solution, as with the current number of referred sessions (5), care facilitation would risk reducing the number of sessions for allied health care available to patients.</p> <p>The group proposes that there should be a separate item for care facilitation as provided by AHWs/AHPs.</p>	<ul style="list-style-type: none"> An integrated care facilitation model improves quality of life and reduces use of hospital resources by patients with chronic obstructive pulmonary disease and chronic heart failure. Stephen Bird A C, Michelle Noronha B and Helen Sinnott, Australian Journal of Primary Health 16(4) 326-333 Ann Fam Med. 2012 Jan-Feb;10(1):63-74. doi: 10.1370/afm.1312. Systematic review and meta-analysis of practice facilitation within primary care settings. Baskerville NB1, Liddy C, Hogg W.



Figure 8: Strengthening the quality of health assessments

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH REFERENCE GROUP

Strengthen quality of Health Assessments (HAs)

[PRELIMINARY]

Question	Draft response	Rationale and evidence
What should be the ingredients of an Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715)?	<p>The ATSIHRG is of the strong view that 715 be retained. There is a need for an evidence-based, best-practice review of item 715 to review the age groups, the ingredients of the health checks, and the tools and instruments used to assess the various aspects of both prevention and management of chronic disease. This review would also need to incorporate the appropriate peak bodies. The ATSIHRG will begin to identify some specifics of these changes will be detailed in the coming weeks, working closely with RACGP/NACCHO.</p> <p>Proposed changes include</p> <ul style="list-style-type: none"> - Changing the age groupings to 0-5, 5-12, 13-25, 26-55, and 55+ to ensure adequate coverage of developmental screening in paediatric populations - Encouraging the use of validated monitoring tools to measure elements of item 715 	<ul style="list-style-type: none"> ▪ Absolute cardiovascular disease risk and lipid-lowering therapy among Aboriginal and Torres Strait Islander Australians: Bianca Calabria, Rosemary J Korda, Raymond W Lovett, Peter Fernando, Tanya Martin, Leone Malamoo, Jennifer Welsh and Emily Banks Med J Aust doi: 10.5694/mja17.00897 ▪ AUDIT C - alcohol ▪ APHQ9 - mood
What evidence exists to support HAs in Indigenous Australian communities?	<p>There is a growing body of evidence to support HAs in Aboriginal and Torres Strait Islander populations. Specifically, HAs help assess and treat cardiovascular disease, and encourage general engagement in healthcare.</p>	<ul style="list-style-type: none"> ▪ Agostino, J, Butler D, Douglas K, O'Donoghue Jenkins L, Skewes K, Phillips C, Paige E, Sturgiss E, Wade V, Korda R, Lovett R and Banks E. Evidence on how Aboriginal and Torres Strait Islander health assessments can be enhanced to support best practice cardiovascular disease risk assessment and management. Report to the Australian Government Department of Health, 2018 (shared in confidence to the MBS Review)

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Figure 9: Allowing Aboriginal and Torres Strait Islander health workers and health practitioners, remote area nurses or a discharging doctor provide a medication management review

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH REFERENCE GROUP

Allow AHWs, AHPs, remote areas nurses, or a discharging doctor to provide a Medication Management Review¹

Question	Draft response	Rationale and evidence
Will this recommendation assist in enabling greater access to Medication Management Reviews for Indigenous Australians?	<p>Medication Management Reviews should stay as pharmacist-led programmes, but AHWs or AHPs could provide local access in remote areas and be the on-site presence for the pharmacist. Telehealth participation by pharmacists with patient-side AHW or AHP presence could further increase access to MMRs for Aboriginal and Torres Strait Islander populations.</p> <p>It is noted that around ACCHOs that employ pharmacists / community pharmacists, MMRs seem to have reasonable take-up</p>	<ul style="list-style-type: none"> ▪ ...

¹ Full text of the referred recommendation: Allow AHWs or AHPs, remote area nurses, or a discharging doctor to liaise via telephone or email with the patient's usual GP and receive the GP's and the patient's consent for a Medication Management Review (MMR)

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Appendix F Referral forms for allied health services

Figure 10: Referral form for follow-up allied health services under Medicare for people of Aboriginal or Torres Strait Islander descent

The section in the red box is optional, but this is not specified on the form.

**Referral form for follow-up allied health services under Medicare
for People of Aboriginal or Torres Strait Islander descent**

Note: GPs can use this form issued by the Department of Health or one that contains all of the components of this form.

To be completed by referring GP

Health assessment completed:

701 ☐ 703 ☐ 705 ☐ 707 ☐ 715 ☐

GP details

Provider Number

Name

Address Postcode

Patient details

Medicare Number Patient's ref

First Name Surname

Address Postcode

Allied Health Professional (AHP) patient referred to: (Specify name or type of AHP)

Name

Address Postcode

Referral details – Use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for up to 5 allied health services (in total) in a calendar year. Indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number	No of services	AHP Type	Item Number	No of services	AHP Type	Item Number
	Aboriginal Health Worker	81300		Exercise Physiologist	81315		Podiatrist	81340
	Audiologist	81310		Mental Health Worker	81325		Psychologist	81355
	Chiropractor	81345		Occupational Therapist	81330		Speech Pathologist	81360
	Diabetes Educator	81305		Osteopath	81350			
	Dietitian	81320		Physiotherapist	81335			

Referring GP's signature Date signed

The AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health professionals should retain this referral form for record keeping and Department of Human Services (Medicare) audit purposes.


Medicare rebates and Private Health Insurance benefits cannot both be claimed for these services. Patients should be advised that they must choose whether to access one or the other.

This form may be downloaded from the Department of Health website at www.health.gov.au/mbsprimarycareitems.

THIS FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS



Figure 11: Referral form for individual allied health services for patients with a chronic medical condition and complex care needs

 Australian Government
Department of Health

Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs

Note: GPs can use this form issued by the Department of Health or one that contains all of the components of this form.

To be completed by referring GP:

Please tick:

☐ Patient has GP Management Plan (item 721) AND Team Care Arrangements (item 723) OR

☐ GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's aged care facility (item 731)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

GP details

Provider Number

Name

Address Postcode

Patient details

Medicare Number Patient's ref no.

First Name Surname

Address Postcode

Allied Health Provider (AHP) patient referred to: (Please specify name or type of AHP)

Name

Address Postcode

Referral details – Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for a maximum of 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number	No of services	AHP Type	Item Number	No of services	AHP Type	Item Number
	Aboriginal Health Worker/Aboriginal and Torres Strait Islander Health Practitioner	10950		Exercise Physiologist	10953		Podiatrist	10962
	Audiologist	10952		Mental Health Worker	10956		Psychologist	10968
	Chiropractor	10964		Occupational Therapist	10958		Speech Pathologist	10970
	Diabetes Educator	10951		Osteopath	10966			
	Dietitian	10954		Physiotherapist	10960			

Referring General Practitioner's signature Date signed

The AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health providers should retain this referral form for record keeping and Department of Human Services (Medicare) audit purposes.

This form may be downloaded from the Department of Health website at www.health.gov.au/mbsprimarycareitems

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

CDAHI 0510