Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?

The Australian Indigenous Doctors' Association (AIDA) is the nation's professional association for Aboriginal and Torres Strait Islander doctors and medical students, and advocates for improvements in Indigenous health in Australia. We are working towards improving the health of Aboriginal and Torres Strait Islander people and reaching parity of Indigenous doctors across the medical profession. We also seek to create a health system that is culturally safe, high quality, reflective of need, and respects and integrates Aboriginal and Torres Strait Islander cultural values. As such our responses are focused on Aboriginal and Torres Strait Islander people, particularly those with chronic and complex health conditions.

AIDA has consulted with our membership base to inform our feedback to this review process.

With regard to this question, there was general agreement among members that the review of the MBS is required and that some parts of the MBS are out of date.

It is timely for MBS item numbers to be reviewed to reflect and support current practice.

AIDA notes that limited consultation times under Medicare do not give the practitioner the time to practice holistic, evidence based, and primary health care. There is also scope to review how doctors and practices, including Aboriginal Community Controlled Health Services (ACCHS) that bulk bill are paid - they should not be disadvantaged because of bulk billing.

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

AIDA would like to make the following point on the proposed MBS Review process:

- Aboriginal and Torres Strait Islander registrars should be allowed to bulk bill under Medicare, provided they have the right supervision. This would be a significant contributing factor to closing the gap in Indigenous life and health outcomes including the mortality gap, and recognising the Indigenous medical workforce.

How can the impact of the MBS Review be measured?

AIDA makes the following suggestions regarding how the Department of Health can seek to improve the measurement and monitoring capability of the MBS over time:

- assessment of the job satisfaction of General Practitioners;
- patient satisfaction when leaving GP bulk billing practices after short consultations;
- level of access of Aboriginal and Torres Strait Islander people to ACCHS (with the view of increasing number and quality of services supplied to Indigenous patients - noting this often corresponds to longer sessions being billed);
- level of access of Aboriginal and Torres Strait Islander people to mainstream health services (also with the view of increasing number and quality of services supplied to Indigenous patients); and
- data should be collected and shared with ACCHS and vice versa.

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

AIDA members have identified lowly renumerated time based services as worthy of consideration under the MBS review. However, we note that any changes should consider the implications on rural and remote and disadvantaged communities and should not be primarily and only founded on a monetary basis. Safety, equity and access should be actively considered.

With advancement in medical technologies, availability of services and increase in the capacity of medical services (for example Cataract Surgery) – relevant MBS item numbers could be reviewed. AIDA also suggests that MBS item numbers for obsolete and unsafe services should be considered as part of this review process.

AIDA notes that overall there is scope to simplify the range and amount of the MBS item numbers to reduce complexity in administering the system in diverse patient care contexts.

Which services funded through the MBS represent high value patient care and appear to be under-utilised?

AIDA members have identified the following services as representing high value patient care but appearing to be under-utilised:

- GP mental health care plan item numbers;
- case conferencing item numbers;
- items 721, 723, 715, 2717, 36, 14206;
- level D consults; and
- acupuncture.

AIDA would like to note that the Aboriginal and Torres Strait Islander health check offered under MBS item 715, although often time consuming, proves very effective for patient engagement and follow up.

Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended?

AIDA would like to make the following points in response to the potential of reviewing some MBS rules and regulations:

- The Medicare rebate is currently frozen but health costs continue to increase above inflation for example, private health insurance companies have been allowed to increase their premiums by an average of 6.2% for the past few years. For ACCHS, whose patients often cannot afford to pay for the health services received, the Medicare rebate freeze means that each year, as health costs rise, their income does not. So essentially the Medicare rebate freeze represents a cut to ACCHS and will impact their services and effectiveness.
- In an ACCHS setting where there is an Aboriginal Health Practitioner, the time based consult items only reflect the actual GP time taken with a patient (for example items 23, 36 and 44). In practice, this would also involve the time of a remote area nurse or Aboriginal health worker in triage, talking with the patient and agreeing on some or all of the management plan - as is culturally appropriate. This additional time and expertise is not renumerated with equity by Medicare as only a small number of items at lesser value can be billed.
- A lot of work undertaken by doctors in ACCHS at present is unpaid by Medicare for example: telephone consults with people who cannot get to the surgery, arranging specialist appointments and other administrative tasks. This is a major barrier to doctors setting up private practices in areas with a large Aboriginal and Torres Strait Islander case load.
- In terms of funding implications for an Aboriginal Medical Service, the level of unpaid work creates a significant financial obligation to cover the wages for doctors, while the remote area nurses and Aboriginal health workers are unable to accurately claim through the MBS for the time it takes to do their important and sometimes life-saving work.
- There would be clear benefit in developing an MBS item number for consults that last more than one hour - this is not unusual in Aboriginal and Torres Strait Islander communities where patients have complex needs and there is a need for translation or other assistance with communication and making plans for next steps.

Are there rules which apply to individual MBS items which should be reviewed or amended?

AIDA notes that ACCHS provide extensive complex and comprehensive service to the patient in a holistic manner and hence there is need for affirmative action including through MBS item numbers. We note that Medicare does not fund the additional work a doctor has to do in an Aboriginal medical service or remote community setting. Among other things, the implications of this may also be that patients do not receive adequate follow up care.

Specific MBS items that do not address the complexity and time required to address the involvement and care provided by doctors on the same day are:

- Level A<6min: MBS item number 3;
- Level B<20 min: MBS item number 23 (most commonly used in mainstream general practice);
- Level C<40 min: MBS item number 36 (most commonly used in ACCHS); and
- Level D>40 mins: MBS item number 44 (There is no item number for services exceeding 40 minutes and most ACCHS provide care for a longer period of time. For example, sometimes patients are transported to and from home, but this is not reflected in the MBS item number. ACCHS also offer other services and procedures to patients, such as iron infusion for example, which were previously done at hospital. These procedures can take a number of hours (including monitoring time) and consume the time of doctors and nurses, but are very valuable in terms of saving hospital resources and patient time. Despite the real time involved, the service must use the Level D MBS item, which is not a true reflection of the care provided by the ACHHS.)
- Regarding the removal of MBS item number 23 (level B) and management plan 721 and 723 in November 2014, AIDA can see potential disadvantages to the way ACCHS offer patient care. This is because most patients presenting to ACCHS for acute service (MBS item number 23) also receive care for a chronic problem (with management plan item number 721 and 723). However, since the 2014 change to the rules, both billings cannot be done on the same day. Given that the proportion of such comprehensive service is higher at ACCHS that do not have a time based appointment system (as prevalent in mainstream services), ACCHS are under a clear disadvantage.
- A further implication of this policy change is the impact on how key performance indicators are reported for the service. This has potential impacts on future policy and budgeting and does not provide reflective Medicare billing data to the monitoring body.

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

AIDA notes the importance of adequately trained support staff in any health service to assist with applying MBS rules and regulations. We recognise the need for ongoing support for development, recruitment, retention, and promotion of staff. AIDA also sees the value in ongoing commitment and affirmative action to support Indigenous Medical students, residents, registrars and doctors, noting the potential of the policy around use of MBS item numbers to support this.

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

AIDA advocates for the provision of culturally safe and comprehensible updates and information being made available to Aboriginal and Torres Strait Islander patients. We note the benefits of a comfortable health setting to improving health outcomes for Indigenous patients. This includes adequate consultation time, opportunities to talk with remote area nurses or Aboriginal health workers and the chance for patients to be fully aware of their management plan (where applicable) and any follow up appointments or activities that are required.