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The voice of rural child health

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Submission to Medicare Benefits Schedules Review Taskforce

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The Australian Paediatric Society (APS) is a Special Society of the RACP representing rural child health and over 300 paediatricians working in rural and remote Australia.

The Australian Paediatric Society notes the absence of any rural based specialist on the Taskforce. The Australian Paediatric Society appreciates the opportunity to review the MBS Review Taskforce discussion paper. We recognise that the model of care for most children is changing and varies from region to region.

In response to the MBS review, the Australian Paediatric Society makes the following comments:

1. It is important that **equity in healthcare remains a core principle**. This principle applies particularly to healthcare received by regional and rural Australians, including the indigenous and the disadvantaged. There are significant disadvantages in terms of access to general practice, specialists and specialist care. Medical consultations may require significant time and distances to travel which impact on work, family dynamics (care for siblings) and school attendance and activities.

2. Rural people are more frequently bulk billed because of lower incomes. Rural people have less access to private hospitals. Rural people have lower life expectancy and more emotional health issues. Rural people have less access to culturally appropriate, highly skilled professionals especially in health services. Appropriate payment for services delivered is intrinsically related to distribution of workforce across Australia. Put simply, metropolitan residents have a greater choice and better health outcomes. Metropolitan doctors can charge well above the Medicare rebate – some exorbitantly. **Accordingly, failure to incorporate workforce and equity of access issues into the MBS review will propagate the fundamental flaw in the overall health system and continue to disadvantage rural and remote Australians.**

3. There continue to be difficulties in attracting quality medical staff, general practitioners and specialists, to regional areas. As well as the lifestyle decisions which keep doctors in the city, there is also a financial penalty in moving to the regional areas which have higher levels of lower socio-economic status populations. **The MBS review should examine options for providing a financial incentive for doctors to reside in regional areas, by providing a Medicare loading for regional consultations.**

The Australian Paediatric Society recommends the following incentive loading priorities:

i. Aboriginal
ii. Remote specialists
iii. Rural Specialists
iv. Telehealth

4. General paediatric practice in regional areas has a high proportion of complex medical cases. At least 50-60% of practice component involves neurodevelopmental, behavioural and social content. Associated health support services are often limited. The regional paediatrician requires prolonged consultation times to act as case manager for these complex cases. **A time-tiered system should recognise the value of prolonged consultation as being equal (minute for minute) to a shorter consultation**. We believe that this should extend for a period of 45 minutes, which would be a reasonable time for an experienced practitioner to assess a complex case.

5. A time-tiered system penalises the experienced practitioner who can synthesise and manage a problem with better efficiency than a new graduate or a practitioner under supervision. **A complexity loading should therefore be maintained**. Avery long (75 minute) consultation is sometimes required to sort out and manage complex combined family, emotional health and chronic disease issues.
   The introduction of the 132 / 133 consultation items was instrumental in improving the financial viability of private general paediatric practice in regional areas. The previous uneconomic MBS item number schedule (110/116) resulted in a progressive transfer of these services to State based salaried specialist outpatient clinics which were often billed to Medicare anyway. Waiting times in public outpatients therefore extended to now exceed 1to 3 years in some regional centres, because public clinics are inherently less efficient in processing patient volumes. The best regional model involves a mixture of public and private out-patients. **Regional patients cannot easily access alternative clinics as in a classic free market model and would face the prospect of higher gap costs to receive timely care.**

6. Indigenous health clinics are an example of the above phenomenon. Many such regional clinics are run by private practitioners, who travel to work out of specific indigenous facilities, and bulk bill the patients seen. The attendance rate can be problematic, and the economic cost is a closed private practice for the day. These clinics are motivated largely by community service (‘paying the rent’), so any financial disincentive merely devalues this close-the-gap effort further.

7. Attention should be given to continue to support incentives for telehealth as an extremely important health service to regional Australians. **The APS strongly disagrees with proposed recommendations to remove incentive loading for telehealth**. The APS is concerned that this may result in less services being delivered or the potential for a fee for service loading which may be difficult to collect unless the patient is forced to travel to the consulting rooms. APS strongly supports telehealth and its expansion.

8. **Case meetings are an integral part of a regional paediatrician's workload and are considered best practice in complex medical conditions**.
    a. APS welcomes treatment planning case meetings and a shorter than 15 minutes item.
    b. Without "on-tap" resources, it is more difficult in regional areas to have all allied HCPs present at the one time even by telehealth. The participants in regional areas should be counted as being involved if contacted after the case meeting (before the summary report is written)
    c. The class of important case meeting participants must be expanded in regional areas where there may be a scarcity of allied HCPs with many having dual roles (the bush nurse acts as many different roles, the occupational therapist acts as psychologist, diabetes educator acts as dietician). School issues are particularly relevant for chronic disease and complex neurodevelopmental and behavioural issues. The school counsellor may act as psychologist. The teacher, office staff or integration aides may have a medical supervision (or therapy) role integral to the child's condition and may be part of the case meeting in the child's best interest. MBS review does not account for these skill sets that are an inherent part of rural health management. The doctor in regional areas should (on good faith and with adequate documentation and validation) include such persons in case meeting.
    d. Case meeting should acknowledge larger collaborations of carers as a marker of complexity.
    e. The MBS should recognise the practitioner taking effort and responsibility to organise case meetings.
    f. General practitioner attendance should be encouraged but not mandatory.

9. Practice Nurses – Only general practitioners are given incentives for practice nurses. **Paediatricians in regional Australia should be encouraged to employ practice nurses** for regional diabetes management (including school visits), allergy testing, opportunistic immunization, eczema and asthma management advice, acute epilepsy management etc.

10. While children in metropolitan areas with chronic disease may access publicly funded outpatient services and on-site pathology, children with chronic disease in rural areas do not enjoy access to the same services. Hence children with chronic disease (such as Type 1 diabetes) in regional Australia should be given more than 5 rebatable allied health visits per year. For regional children to experience management consistent with NHMRC and international ISPAD guidelines,10 rebatable visits should be allowed.

11. **Regional paediatricians should be able to generate a Chronic Disease Plan** (as part of consultation) for a few select chronic disease for which they are entirely responsible (e.g. Type 1 Diabetes). Savings from not being required to attend a general practitioner could be translated to actual services by the Diabetes Educator or psychologist etc.

12. APS supports **incentivization of best practice based on measurable outcomes**.

The APS acknowledges the need to review the MBS schedule. Many innovations in the current MBS schedule are however the result of evolution based on refinement of a working model. The APS appreciates the opportunity to submit our views on the MBS review and look forward to a system that

provides better but also equitable healthcare for all Australians, the indigenous, the disadvantaged, and those in regional and rural areas.

The APS offers to assist further so the Taskforce has a voice of a rural specialist

Yours sincerely

Mark De Souza

President

Peter Goss

Treasurer