Clinical Oncology Society of Australia

20 July 2018

Professor Bruce Robinson
Chair, MBS Review Taskforce
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Dear Professor Robinson

Re: MBS Review Taskforce – feedback on the draft Oncology Clinical Committee report

Thank you for the opportunity to review and comment on the Medicare Benefits Schedule Review Taskforce, Oncology Clinical Committee draft report. We are pleased to provide the following general principles as well as responses to the specific questions from the Taskforce.

General principles

COSA believes the spirit of the Review is well intended, and the process undertaken has produced some sound recommendations for the existing items. This is an initial step towards greater alignment of the MBS with contemporary clinical practice. This is also an opportunity to address the deficiency in the quality and timing of end of life care discussions as part of modern medical oncology. Further opportunities exist within the MBS to improve the care provided to Australians through greater equity of access and by influencing cultural change.

The MBS has the capacity to support the adoption and utilisation of new and emerging evidence-based practices. The system must encourage innovation and development of beneficial, efficient and less costly treatment options as evidence changes.

The detail regarding the proposed changes to the MBS item numbers is scarce. We are concerned that some of the proposed changes will have significant unintended consequences, and these changes could fundamentally alter the models of remuneration which could:

- Threaten the viability of cancer treatment in the public and private sectors
- Lead to increased pressure in a public hospital system that is already straining under current workloads
- Increase patient out of pocket expenses

COSA is very concerned that the Committee is recommending these changes without piloting them or undertaking modelling (although we recognise some modelling work is planned).

We appreciate the process to value MBS item numbers is separate to this Review; however, COSA cannot fully support all the changes without a complete understanding of the economic impact to the health system and those that work in it, as well as cancer patients.

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Responses to Taskforce questions

1. Do you agree/disagree with each of the 10 recommendations in the report?

Recommendations 1 and 2

COSA supports these recommendations.

In particular COSA welcomes:

- The streamlining and simplification of item numbers
- The inclusion of oral agents and monoclonals, and all systemic anti-neoplastic therapies with substantive toxicity
- The inclusion supervision of therapy and the recognition that the supervision of oral agents requires significant time and expertise therefore requires appropriate compensation
- The inclusion of other elements of care such as the management of side effects

Recommendation 3

COSA supports this recommendation for both medical and radiation oncology, and recommend the medical oncology community also be engaged not only radiation oncology. A pilot of the changes would also be pertinent as part of the exercise modelling, ensuring the relevant settings are covered, ie public and private, regional/rural and metropolitan, adult and paediatric.

We provide further comment below at question 3, and defer to RANZCR for additional detail

Recommendation 4

COSA supports this recommendation, and defers to RANZCR for additional detail.

Recommendation 5

COSA supports this recommendation, and defers to RANZCR for additional detail.

Recommendation 6

COSA supports this recommendation, and defers to RANZCR for additional detail.

Recommendation 7

COSA supports this recommendation, and defers to RANZCR for additional detail.

Recommendation 8

COSA supports this recommendation, and defers to RACS for additional detail.

Recommendation 9

COSA supports this recommendation, and defers to RACS for additional detail.

Recommendation 10

COSA supports this recommendation, and defers to ANZCHOG for additional detail.

2. Are there aspects of medical oncology that have not been considered as part of this report that you consider require further investigation?

i) End of life care

Given that most initial consultations need to include discussions on diagnosis, aim of treatment, management plans, discussing side effects and end of care issues and usually takes an hour, a comprehensive item number to cover first consultations is necessary to make sure doctor spend enough time covering all these important aspects and patients receive all the necessary information to make their treatment choices and end of life plans.

We suggest:

a) a comprehensive item number for consultations lasting up to an hour to cover discussions on diagnosis, aim of treatment, developing care/management plans, and side effects

b) a separate item number to cover "end of life care discussions" and/or "advanced care planning by medical oncologist" will be important to encourage medical oncologists to take on this important aspect of care and help the patient earlier in the patient journey. Currently, this discussion does not happen in a timely manner mainly due to time constraints and is often left until late (i.e. days or weeks before death) or does not occur at all.

ii) Multidisciplinary teams (MDT)

Multidisciplinary care is a best practice approach to the delivery of cancer care. The multidisciplinary care team (MDT) is representative of all specialists involved in cancer care and facilitates a balanced discussion of the patient's diagnosis or case to ensure all available treatment options are considered. Improved application of existing items and/or modification of current criteria will aid the adoption of multidisciplinary care as standard practice, accessible to all patients, in all settings. MBS items could incorporate the requirement of the provider to have access to an MDT to claim the item. This would promote the involvement of multiple practitioners and health services to support multidisciplinary collaboration and networking. We defer to our colleagues at Cancer Council Australia for further detail.

Secondly, case discussion at MDT meetings is a key initiative to improve the quality of care of cancer patients. It is both Australian and State Government policy that all patients with cancer should have their cases discussed at a MDT meeting. The proportion of cases discussed across Australia is increasing, but is still not at an optimal level. MBS items were introduced to support case discussion, but the uptake of billing has been low, at least in part due to stringent rules. However, minor modification of these rules would likely improve uptake and help achieve a greater level of case discussion.

Currently there is a requirement that a case be discussed for a minimum of 10 minutes for MBS billing to be allowed for presentation of the case. To date, the 10 minutes has been interpreted as the duration of the discussion of that case at the MDT meeting. However, it is usual practice now for the discussion to be shorter as considerable time is spent by doctors preparing for the case discussion, including the clinician who presents the case at the MDT meeting as well as the pathologist and imaging specialists.

COSA proposes the requirement for a case to be discussed for a minimum of 10 minutes be changed to allow preparation time by medical practitioners, as well as the preparation of the written outcome including the letter to the referring GP or specialist, to be included in the 10 minutes. We also recommend a health economist be engaged to provide data on the actual costs to deliver a multidisciplinary consultation.

3. ***In relation to recommendation 3 (conducting an impact assessment modelling exercise for the megavoltage restructure), what in your opinion are some of the factors that you consider should be taken into account as part of this exercise?***

It is reasonable to restructure the megavoltage payment into two levels based on complexity, and to conduct an analysis to assess the impact of the proposed model. However, the number and structure of the institutions involved may not be representative of the current practice in Australia, and the six-month duration may not be sufficient to capture all necessary data. COSA suggests reviewing relevant MBS billings over one year (e.g. using Medicare Item Reports) and map these to the new payment model. To improve impact analysis, extrapolation may be useful to predict the future uptake of the new structure.

Once again thank you for the opportunity to be involved in this important work. We look forward to contributing to future consultation by the MBS Review Taskforce.

Please do not hesitate to contact me if you require further information of clarification.

Yours sincerely

Marie Malica
Chief Executive Officer
(on behalf of the COSA Board and Council)