7 June 2019

Dear Professor Robinson and the Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC),

ACSEP appreciates the efforts of the MBS Taskforce Review and all its committees to improve value, equity and access to best-practice healthcare for all Australians.
The ACSEP welcomes the opportunity to comment on the SCPCCC Report submitted by the Medicare Benefits Schedule Review Taskforce in December, 2018.

There is an issue of considerable concern to ACSEP which has not been addressed within the SCPCCC recommendations.

## ACSEP Trainee MBS Rebates

ACSEP trainee A2 rebates have remained at non-Vocational Registered, non-indexed levels since 1991, limiting patient access to SEM services and also limiting the capacity to provide optimal training for the sport and exercise medicine workforce. As a result, ACSEP trainees are heavily reliant on surgical assisting fees for income during their training. Whilst limited exposure to orthopaedic surgery is helpful for the learning experience, ongoing work of this nature is not required for SEM training. The College recently had AMC reaccreditation approved through to March 2025, and the poor static rebates pegged at 1991 levels relative to the cost of living and training threaten the viability of the training program in its current format.

Unfortunately, the issues of ACSEP Trainee rebates HAS NOT BEEN ADDRESSED by any committee within the MBS Review process.

ACSEP requests that fit for purpose MBS item numbers be issued to ACSEP trainees

- reflective of its community based training program
- appropriate with other community based specialist trainee programs e.g. RACGP
- provide equitable access and reduced out-of-pocket expenses for patients of ACSEP trainees.

The ACSEP supports all recommendations made within the SCPCCC Report but wishes to make the following comments.

**Recommendation 1 - Introduce time-tiered attendance items**
Supported
For many years, patients seeking services from Sport and Exercise Physicians have suffered inequitable access due to large out of pocket expenses consequent upon the application of A3 consultation rebates for services that are largely consultative in nature.

*4.7 Improve access to specialists who are highly consultative but can currently only access A3 specialist attendance items (for example, sports and exercise medicine, dermatology).*

ACSEP thus welcomes the recommendation for a time tiered rebate structure that offers equity, simplicity and improved transparency for consumers whilst reducing disincentives to choosing procedural treatments. This will improve access for Australians with chronic conditions such as osteoarthritis, and back pain in addition to the activity related medical and musculoskeletal problems traditionally seen by SEM physicians.

**Recommendation 2 – Introduce new attendance items for acute, urgent and unplanned attendances**
Supported, additional consideration

The Committee recommends:
a. creating four new time-tiered attendance items for acute, urgent, and unplanned attendances;

b. specifying that these items are only to be used in specific situations where the attendance is acute, urgent, unplanned, and does not take place in the consultant specialist's consulting rooms or in the emergency department of a public hospital;

For consideration
Whilst ACSEP supports this recommendation, it notes that this would not include acute injury management (e.g. concussion) provided at community sporting events. Professional sports coverage is typically remunerated by contractual arrangement outside the MBS, but unpaid community work may be provided by both ACSEP Specialists and Trainees. ACSEP appreciates this is a unique situation, but that events are a legitimate workplace location for SEM physicians and others and that medical support at these locations is of value to the community and aligns with safe sport principles on the National Sport Plan 2030.

ACSEP requests access to non-referred MBS item numbers in order to continue to provide acute injury and medical management at sporting events. We ask for this situation to be clarified in order to continue to provide appropriate event medical coverage.

**Recommendation 7 – A new framework for telehealth**
Supported with additional consideration

ACSEP welcomes the simplification for telehealth service payment structure. It notes, however, that access should be made available for all patients in a consumer centric fashion, and not be limited to those patients where geographical access is limited. ACSEP acknowledges that many metropolitan Australians (acknowledging the recommendation for telehealth access for all ATSI and aged care patients) have reduced access to health service by means of time, lack of work flexibility, lack of transport or child care etc. Patients from lower socioeconomic backgrounds have poorer health outcomes across many domains, and universal access to healthcare can be facilitated by the use of telehealth for all Australians regardless of geography. This reflects global trends in telehealth service delivery. Note that the UK provides 3% of outpatient consultations via telehealth in the absence of geographical or other restrictions.

**Recommendation 10 - Introduce case conference items for allied health professionals (AHPs) and nurse practitioners**
ACSEP acknowledges the important role AHP have in patient care and welcomes fair access to all members of the multidisciplinary case conference. ACSEP strongly supports this recommendation.

**Recommendation 19 – Introducing a new AHP pathway**
Supported
ACSEP also supports the recommendation put forward by the GPPCCC to review the evidence and the associated costs and benefits of creating an AHP pathway for consultant specialists under certain circumstances, to improve access for patients and streamline access to relevant multidisciplinary treatment.
SEM physicians work closely with physiotherapists, exercise physiologists and psychologists to deliver value based exercise interventions.
ACSEP acknowledges the key role a patient's GP plays in co-ordinating their care, and that any such direct to AHP pathway should include full communication back to GPs. It also acknowledged, however, that frequently patient consumers seek referrals from practitioners *other than* their primary GP for reasons of cost and convenience, and thus the intention of keeping the GP at the centre of care is often, in practice, not realised.

Yours sincerely

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