AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA submission to the Senate Standing Committees on Community Affairs – Inquiry into the Disability Support Pension (DSP)

Email: community.affairs.sen@aph.gov.au

Comments on the impact of 2015 reforms which removed the Treating Doctors Report and replaced it with existing medical evidence

Following the implementation of the 2015 reforms, which removed the Treating Doctors Report (TDR) the AMA has received largely positive feedback from GPs. The change has been largely welcomed having streamlined the administrative requirement for practitioners when a patient has a DSP claim. Prior to this, GPs were not properly funded for preparing the Treating Doctors Report and also felt the report put them in a difficult position with patients if they were not eligible for DSP or their claim for DSP was not successful.

It should be noted that a GP's day is structured with a primary focus on the provision of clinical care. Most GPs are private practitioners who are reliant on fee for service. Without adequate remuneration under the MBS, their capacity to spend time on administrative tasks such as report writing is very limited, unless they privately bill the patient for the service. This can then be cost prohibitive for patients who are often already struggling financially due to the nature of their illness/condition/impairment.

While GPs are allowed to claim a consultation item under the MBS for assisting patients with compiling the medical evidence for their claim, this is not clearly articulated in the consultation descriptor. Many GPs are unaware they can claim for this, and without it being clearly stated in the descriptor are reluctant to claim it, for fear of falling foul of compliance requirements. In addition, there is a fundamental imbalance with GP consultation items under the MBS. The current MBS item structure discourages GPs from spending time with patients and until the MBS is restructured to reward longer consultations, spending significant amounts of time with patients and reviewing records as part of the preparation of a TDR is unviable.

Comments on the impact of 2015 reforms which introduced Disability Medical Assessment by the Australian Government contracted doctor

Doctors prefer that the assessment for DSP is carried out by Government employed/contracted practitioners who fully understand the eligibility requirements, the medical evidence required, and the relevant legislation.

GPs are open to being contacted by a Job Capacity Assessor (JCA) or Government Contracted Doctor (GCD) if further information about the status of a patient's condition/s or the impairment/s experienced by the patient is required, provided they are adequately funded for their time and can schedule the interaction. GPs are often unaware that they can request payment for their time when providing addition information to a JCA or GCD. The information on this, made available via the Services Australia website is vague, with no information on how a GP can claim this payment and what the rates of payment are.

GPs would also welcome a "closing of the loop" regarding the outcome of a patient's DSP claim, and the reasons in the event of an unsuccessful claim. This would assist GP's as they continue to care for the patient and to support them should they seek to lodge another claim.

Comments on whether the Treating Doctors Report should be re-introduced and why

The AMA does not see the need for a return to the TDR. We have not had calls from our membership for this.

What is needed is clearer and better funding mechanisms to support GPs in compiling/and or summarising the medical evidence to support a patients claim.

The MBS does not adequately support the preparation of reports by GPs that specifically address the fully diagnosed, treated and stabilised requirements and the functional impairments against the tables. Such reports take time to prepare and this needs to be scheduled into the GP's day. A consultation appointment for this purpose is one way to do this but current MBS consultation item descriptors do not allow for this, and in any event, nor does the structure of the MBS consultation items adequately support GPs to spend time on preparing these reports.

Amending the descriptors for MBS consultation items to make it clear that the relevant consultation item could be claimed solely for completing any report required to enable a patient to obtain a government benefit would be a starting place to see GPs and their patients better supported. While such documentation is often better done with the patient present, it may not always be practical. For example, if the consultation time booked has already been utilised addressing clinical issues and the patient cannot readily return because they have mobility issues, limited access to transport or live a considerable distance away (ie rural).

This would reduce costs for patients in obtaining the medical evidence for their DSP application by ensuring a Medicare rebate and corresponding bulk-billing incentive for eligible patients are applicable.

Comments on what other tools, information, or support would assist health professionals providing medical evidence for a DSP claim

GPs need to be supported with Continuing Professional Development (CPD) accredited training on the use of the DSP Impairment Tables and understanding DSP eligibility and reporting requirements.

The Health Outcomes International (HOI) report suggests variable levels of awareness and usage among Treating Health Professionals (THPs) of the medical evidence checklist. Our own investigations support this with GPs unaware what remuneration options are available to them, where to access these and how to use the Impairment Tables. This could then affect the quality of any report provided as supporting evidence.

Comments on DSP eligibility criteria, assessment and determination

The AMA has worked with Services Australia and the Department of Social Services over the years in an attempt to ensure that practitioners and patients are aware of:

- DSP eligibility criteria,
- the types of medical evidence required to support a DSP claim, and
- current remuneration arrangements.

However, the AMA believes that more needs to be done to increase GPs, non-GP specialists and Allied Health providers awareness of the Impairment Tables and their use. Current information available on the Services Australia website for GPs regarding DSP claiming does not, for example, make it clear that evidentiary reports that specifically address the impairment levels experienced by the claimant will be of greater assistance in processing a claim than those that do not.

The reliance on existing medical reports can be problematic in that a report from a non-GP specialist to a GP for example may confirm a diagnosis and suggest a treatment or management plan, but it may not articulate the functional impairment a patient is experiencing. This limits the benefits of medical reports in the assessment of a claimant's functionality. Continuing Professional Development (CPD) accredited training on the use of the DSP Impairment Tables and understanding DSP eligibility and reporting requirements would help address this.

The DSP requirement for the disability or medical condition to be fully diagnosed, fully treated and fully stabilised can also be an issue for the following reasons:

- defining "stabilised" is problematic when the patient may experience impairment that is progressive, episodic or fluctuating;
- the patient may have a degenerative disease that is progressively impacting on their functionality and thus not clinically considered stabilised; and
- defining a condition as treated is difficult when emerging treatments can be on the medical horizon.

The AMA also suggests that for people with episodic and degenerative conditions the requirement for a condition to be fully diagnosed, treated and stabilised needs to be applicable to the disease stage.

Finally, patients with mental health and psychological issues often additionally suffer issues of access and equity when it comes to care and treatment for their condition because of the financial constraints they experience due to their condition. Accessing the services of private psychiatrists and clinical psychologists is often impacted by workforce shortages, is cost prohibitive and waiting lists for publicly funded access are long, precluding timely diagnosis and treatment.

It is unacceptable that, despite this competence and experience, any GP diagnosis of a mental health condition must be corroborated by a third party. GPs have extensive experience in diagnosing and caring for patients with mental health and psychological issues and most GP mental health services are claimed by GPs who have undertaken additional mental health training[1]. Psychological issues are the most seen presentations in general practice, with 64% of GPs reporting it in their three most common reasons for patient presentations[2]. Yet, despite this any GP diagnosis of a mental health condition must be corroborated by a clinical psychologist with evidence as to the patient's functional impairment[3]. GPs diagnose and manage the full gamut of mental health and psychological conditions, just as they do for physical conditions. Their diagnosis should stand on its own merits without the need for corroboration of a third party. GPs will always seek specialist opinion where the patient's condition or the treatment required is outside their scope of practice.

8 DECEMBER 2021

Contact

Michelle Grybaitis
Senior Policy Advisor
General Practice Section
Ph: (02) 6270 5496
mgrybaitis@ama.com.au

[1] MBS Statistics on Items 2700, 2701, 2713, 2715, 2717 July 2019 to June 2020: See http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?_PROGRAM=%2Fstatistics%2Fmbs_item_standard_report&DRILL=ag&group=2700%2C2701%2C2713%2C2715%2C2717&VAR=services&STAT=count&RPT_FMT=by+state&PTYPE=finyear&START_DT=201907&END_DT=202006

[2] The Royal Australian College of General Practitioners. General Practice: Health of the Nation 2020. East Melbourne, Vic: RACGP, 2020

[3] Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011, Table 5 Mental Health Function

*Using data on the number of claims lodged in 2018-19 from the Health Outcomes International (HOI)- Department of Social Services Evaluation of the Revised Disability Support Pension (DSP) Assessment Process – Final Evaluation Report – 27 November 2020 (p 69) and population data for 2019 (https://www.statista.com/statistics/263740/total-population-of-australia/)