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AMA Submission to the Aboriginal and Torres Strait Islander Health Reference Group of the Medicare Benefits Schedule (MBS) Review Taskforce.

Introduction

As the peak professional organisation representing medical practitioners in Australia, the Australian Medical Association (AMA) welcomes the opportunity to provide a brief submission to the MBS Review Aboriginal and Torres Strait Islander Health Reference Group. Our suggestions cover the following topics:

- mental Health;
- chronic conditions management;
- substance misuse rebate items; and
- Aboriginal health check.

1. Mental Health

Mental Health Consultations Using Focussed Psychological Strategies (FPS)

There is a lack of access to bulk billing psychologists and there is an established accredited level 2 mental health training for general practitioners (GPs) to provide upskilled cognitive behavioural therapy, interpersonal therapy, family counselling and narrative therapy in a holistic, integrated fashion using the FPS **Medicare** items.

Recommendation 1

The proposal would be to:

- Allow **accredited, non-Vocationally Registered (non-VR) GPs** to rebate the FPS item. This was only stopped very recently and the reality is that in a lot of Aboriginal communities, non-VR GPs are providing the bulk of primary health care.
- **Increase rebate sessions** to more than 10 for GPs as well as psychologists.
- **Expand therapeutic modalities** to include Eye Movement Desensitization and Reprocessing (EMDR), other healing therapies (including traditional).
- Allow **teleconsultation rebates** for GPs who service rural and remote areas.
- Allow rebate items for **group therapy** work by GPs who often work collaboratively with Aboriginal workers in wellbeing groups.

2. **Chronic Conditions Management**
   - **Allow co-billing consults with care plan** development which was stopped in 2015. This would reflect the "one-stop shop" approach to delivering health care to Indigenous patients where consultations incorporate medical management as well as care plan development.
   - **Allow team care arrangements to include Aboriginal social workers** (non-accredited). Aboriginal health services employ Aboriginal workers who may only have a Certificate IV, but play an integral part in supporting the implementation of care plans through cultural advocacy and trust.
   - The **review of care plans** do not attract the same dollar value as the development, but a lot of work is done to problem solve whilst the review takes place, so an increase in the dollar value for MBS Item 732 should be considered.
   - **Increase number of allied health sessions** that can be rebated to reflect the extent that Indigenous people suffer from significant disease progression and co-morbidities.
   - **Shared Medical Appointments** (SMAs) to provide advice on healthy living, risk factors and managing common chronic conditions would be in line with wellbeing programs run in Aboriginal community-controlled health services. Clinicians supporting this approach should have a **Medicare** item they can use. SMAs were developed in the United States to improve access to care, utilise peer support, reduce costs and improve patient and provider satisfaction in the management of chronic disease. An SMA is a comprehensive medical visit, not just a group education session, where a significant part of the added value comes from the facilitated peer interaction, particularly around aspects of self-management and empowerment.
   - **Case conferencing** is a **Medicare** item that should stay as it enables GPs to discuss and coordinate medical management for complex cases with allied health and specialists.

3. **Substance Misuse Rebate Items**

   Indigenous communities are disproportionately afflicted by substance misuse disorders that are often complicated by associated co-morbidities including mental illness as well as polysubstance abuse. This presents a significant challenge for the treating clinician. In this context a **Medicare** rebate item that pays better than a standard long consult (40) would reflect the higher management skills of the clinician treating Indigenous clients with substance misuse disorders.

4. **Aboriginal Health Check**

   A re-design of the template that incorporates better qualifiers as well as creating **Medicare** associated reviews similar to care plans.

<u>National Mental Health Commission Report</u>

- (Volume 1, Recommendation 13, page 95):
  - For severe or complex disorders, enable an extra six Better Access sessions of psychological treatment as clinically determined (a total of 16 in any one year).
  - Two possible resolutions to the problem: (1) reinstating the original 18 session limit which was available prior to 2011, or (2) providing a fairer balance between the number of psychiatry visits accessible in **Medicare** (50 visits) by comparison to psychological care (just 10 visits).

- (Volume 2, page 118):
  - Access to adequate services, ensuring that the number of subsidised therapeutic interventions is able to be tailored to the complexity and severity of individual need. This is much cheaper than artificially curtailing the number of sessions and leaving a person 'lost' to the system and without professional support.
- (Volume 2, page 153):
  - "The Commission also considers that the number of sessions offered under Better Access should be based on clinical need and outcomes, rather than a pre-designated number of sessions."

National Institute of Clinical Excellence (NICE)

NICE Guidelines identify 46 Randomised Controlled Trials supporting Cognitive-Behavioural Therapy (CBT) for depression, with a recommendation for 16 to 20 sessions of therapy.

Australian Psychological Society (APS)

The 2010 APS review identifies a strong evidence-base supporting the use of CBT for the treatment of Generalised Anxiety Disorder, Panic, Specific Phobia, Social Anxiety Disorder, and Obsessive Compulsive Disorder. The number of individual psychotherapy sessions across these studies ranged from 10 to 30 appointments.

Cochrane Review

A Cochrane Review was conducted in 2007 indicating that trauma-focused CBT, stress management and EMDR were effective treatments for Post-Traumatic Stress Disorder (PTSD).

The Australian Guidelines on the Treatment of PTSD developed by the National Health and Medical Research Council in 2007 provide extensive information drawn from several reviews of the research. Following diagnosis, assessment and treatment planning, the guidelines recommend that 8 to 12 sessions of trauma-focused therapy are normally required for the successful treatment of PTSD. In the case of multiple traumatic events, or in instances where there are trauma-related bereavements or disabilities, further sessions are indicated. In cases where there are significant trust issues as a result of a person's traumatic experiences or difficulties in regulating emotions, the guidelines recommend a more gradual treatment approach. The National Health and Medical Research Council guidelines point out that in many cases 90-minute consultations are needed to carry out therapeutic tasks.

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