RACGP
Royal Australian College *of* General Practitioners

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Professor Bruce Robinson
Chair
MBS Review Taskforce
MBSReviews@health.gov.au

Dear Professor Robinson,

Re: MBS Review Taskforce – Report from the Eating Disorders Working Group 2018

The Royal Australian College of General Practitioners (RACGP) thanks the MBS Review Taskforce for the opportunity to comment on the Report from the Eating Disorders Working Group (EDWG).

The RACGP acknowledges that the major focus of the proposed MBS item numbers is on the extreme health and mortality risks for patients with severe anorexia nervosa (AN). However, the RACGP would like to highlight that many patients with severe ongoing and life threatening mental disorders (in particular patients who may not be able to access high intensity mental healthcare) would also benefit from similar intensive interventions.

The report supports general practitioners (GPs) as being the main primary healthcare provider, with an emphasis on early assessment and identification of the eating disorder, and participation in well integrated, multidisciplinary team-based care.

The RACGP notes, however, there is currently little in the recommendations relating to supporting GPs as the main primary health care provider (*5.1.2*) and recommends that this be strengthened. The focus is largely on expanding the funding for secondary and tertiary specific care, and GPs are framed in these recommendations only as the initial assessors and referrers. Further consideration of how to support rural and remote GPs in managing and treating patients with serious AN, in light of specialist services being unavailable.

Similarly, a stepped care approach to treatment (*5.1.4*) requires some form of stratification of the target population, with supported access to the interventions at an appropriate level of intensity. The recommendations provide no additional material support for patients with mild to moderate severity eating disorders, and a significant expansion of access for those with a severe disorder. For instance, as an analogous alternative, mental health services that have been commissioned at a local level (Access to Allied Psychological Services - ATAPS, currently through Primary Health Networks) have tended to be much more equitably delivered, and targeted to population needs. The design of this can be more explicitly 'stepped' and integrated with local hospital based services and private services. Design of a major initiative in this manner is also more likely to reduce the risk of price inflation of allied health services, consider workforce implications, and allow for the embedding of evaluation.

The RACGP provides specific comments relating to the recommendations:

Recommendation 1.1 – *creation of new MBS consultation item for the treatment and management of a patient with severe AN, as diagnosed by a psychiatrist or paediatrician with development of a treatment and management plan, and allowing eligibility for up to 40 psychological and 20 dietitian sessions per year*.

Whilst the intention is to retain GPs as being central to the treatment and management of a patient with eating disorders, the proposed new MBS item number for patients with severe AN, may risk moving them into the tertiary system and losing the ongoing holistic patient centred care that can be provided in the general practice setting. It should be noted that general practice has a role in relapse monitoring after recovery from severe AN.

The RACGP recommends that the number of allied health visits are reviewed by the treating GP at relevant intervals, to confirm that these have been conducted in accordance with the treatment plan and in line with the patient's overall health needs and the principals of good stewardship of healthcare resources.

The RACGP also notes the risk of the following unintended consequences from the introduction of a new MBS item number with the requirement of diagnosis by a psychiatrist or paediatrician:

1. *Inequality of accessibility* – similar to the Better Access to Mental Health initiative, it is probable that people living in the most advantaged socioeconomic status (SES) areas will receive the most benefit, with considerably less accessibility to people living in disadvantaged SES areas.
2. *Inflation of disease severity* – the disparity in access to MBS rebates between those with mild-moderate and severe disease is very likely to promote the inflation of disease severity categorisation
3. *Inflated disease diagnosis* **–** the access to MBS rebates for AN as the only diagnosis is very likely to promote the reclassification of eating disorder diagnoses towards AN.
4. *Impact on existing public hospital services* **–** the proposed increase in rebates for private psychology and dietetics may result in public hospital outpatient services being withdrawn or significantly reduced, inadvertently shifting costs from States to the fixed pool of Medicare funding.

Recommendation 1.2 – *any future work on the MBS items for mental health services consider the needs of patients with moderate cases of eating disorders with a view of increasing access to appropriate evidence based care.*

The RACGP strongly supports the role of general practice in identifying and coordinating treatment for mild to moderate eating disorders. Future MBS items for patient rebates for mental health services described in this recommendation should be accessible after referral by GPs. This would facilitate timely and affordable access including to patients from rural and regional areas.

The RACGP notes that further clarification needs to be sought around the identification and diagnosis of 'moderate' eating disorders, and what subtypes of eating disorders are included.

MBS items for mental health services should also be available to facilitate delivery of mental health services by adequately trained GPs to provide services within the familiar setting of their general practice.

Recommendation 2.1 – *expanding access to provide multidisciplinary case conference MBS items 735, 739, 743 and to item 729 (contribution to a MDT care plan prepared by another practitioner) to allied health and mental health professionals who are specialised in the treatment of eating disorders to enable these practitioners to be remunerated for their involvement in MDT care plan development and case conferences.*

Case conferences are convened to discuss patient history and identify a patient's multidisciplinary care needs. GPs are in a key position to provide these services. While it is appropriate to identify an MBS item number for allied health practitioners to attend (in person or by telephone), allowing 'asynchronous' case conferencing, it is essential that GPs remain engaged in and are not excluded from the case conferencing process, even if all participants are not physically co-located.

Regarding improving service integration, the EDWG states that the minimum core requirement in the treatment of a person with an eating disorder should consist of a medical practitioner (GP or a paediatrician), a mental health practitioner (e.g. clinical psychologist, registered psychologist, psychiatrist, mental health nurse) and a dietitian.

The RACGP upholds the generalist nature of general practice and supports all adequately trained GPs in having a role in treating patients with eating disorders and monitoring patients to prevent relapse. Those GPs who have undergone substantial mental health training, and are qualified to provide evidence-based treatments such as cognitive behavioural therapies should also be included on the list of 'appropriately trained health professionals' able to provide eating disorders specific treatments.

Recommendation 3.2 – *Development of specific training, education and clinical guidance for working with people who have eating disorders, which should be included in continuing professional development programs for disciplines involved in the treatment and management of patients with eating disorders, and in particular, any health professionals providing services under the new MBS items.*

In terms of the development and broad adoption of eating disorder specific training within general practice, GPs who undergo substantial mental health training and are qualified to deliver evidence-based treatments, are well suited to provide treatment and management of patients with eating disorders.

The RACGP would like to bring attention to page 45 of the EDWG report which cites an RACGP news article (reference 73) which suggests '*the inclusion of the Eating Disorders Screen for Primary Care*

and/or Sick, Control, One Stone, Fat, Food (SCOFF) screening tools be embedded within a standardised screening checklist to support the recognition of symptoms within general health screening'. The RACGP would like to clarify that this reference is a news article expressing an opinion by a psychologist, and not an RACGP guideline. The RACGP does not, at this point in time, support routine general health screening of eating disorders in general practice.

Recommendation 3.3 – *Establishing a credentialing process, specific to practitioners that provide treatment for patients with eating disorders, these credentials should be used to determine practitioner eligibility to provide eating disorder services under the new MBS item that is recommended within this report.*

The RACGP does not support specific credentialing of GPs to provide interventions for eating disorders. GPs have extensive training and ongoing professional development in holistic care of patients, including those with mental illness. GPs are well used to making judgements about the need to refer patients to specialist services. GPs with training, skills and capacity to provide psychological interventions should be able to provide these services with access to appropriate MBS rebates for their patients. Any requirement for GPs to undergo a specific credentialing process would act as a significant disincentive.

The RACGP also has concerns that credentialing processes may have unintended consequences of reducing access and affordability to appropriate allied health providers.

Thank you once again for the opportunity to provide feedback. We look forward to hearing about this Review's progress and outcomes.

Yours sincerely,

Dr Harry Nespolon
President